Curriculum Reform in an Australian Medical School: A Narrated Journey

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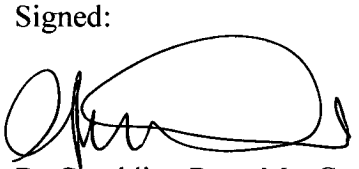

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Abstract

This study investigates curriculum reform in an Australian Medical School which has taken the decision to significantly reform its medical curriculum. The thesis elucidates the lived experience of key members of the curriculum reform team that was established in support of this decision.

The study is located in the three year curriculum planning phase leading up to the decision by the external accrediting body to permit the medical school to replace the long standing 6-year traditional program with a shorter better (5-year) integrated and case based medical curriculum.

The major premise of this study is that through an understanding of the lived experience of change by medical faculty in a medical school undergoing significant curriculum reform and governance restructure, it will be possible to better appreciate the complexity of change in the medical education setting. The aim is to enhance (and problematise) established theoretical understanding of change management in a medical school using narrative inquiry which permits a more in depth and detailed understanding of curriculum reform in the context of the medical school.

Data collected over the three years of the study included the author's personal reflexive journal, interviews with contemporary colleagues on the curriculum reform team, all text data generated by the curriculum planning project over the three years and interviews with former Deans of the same medical school from the school's inception in 1965.

A greater awareness of the lived experience of curriculum reform in medical education is particularly relevant as medical schools nationally and internationally seek to adopt best practice in training future doctors. Increased accountability as well as educational

and health care developments call for increased sophistication on the part of medical teachers within medical schools who are called upon to continually examine how best to educate future health professionals.

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Acronyms

AMA	Australian Medical Association
AMC	Australian Medical Council
ATG	Assessment Task Group
CanMED	Canadian Medical Education Directions for Specialists 2000
CBL	Case-Based Learning
CCTG	Curriculum Content Task Group
DHHS	Department of Health & Human Services (Tasmania)
EFT	Equivalent Full Time
FHS	Faculty of Health Science
GMC	General Medical Council
MCQ	Medical Choice Questions
MEC	Medical Education Committee
MedSAC	Medical School Accreditation Committee
MEU	Medical Education Unit
NCWG	New Curriculum Working Group
OSCE	Observed Structured Clinical Examination
SETL	Student Evaluation of Teaching and Learning
SWCSWG	State-wide Clinical Schools Working Group
TTG	Themes Task Group

Chapter 1 – Research Context

Background

This study began in late 2002 during my tenure as Coordinator of Medical Education and later Director of a newly formed Medical Education Unit at an Australian Medical School – the Southern State School of Medicine (SoM)[1]. My role and the role of the unit that formed around me as originally defined by the Dean of the medical school was to "coordinate" (hence the original title of the post) the school's curriculum development effort and provide educational support to staff to help them implement recent recommendations for curriculum reform made by the school's accrediting body – the Australian Medical Council (AMC) – during a visit in 2001[2]. Over the course of the first year my role rapidly expanded to include leadership of the development of a new "modern" integrated 5-year medical program which was to replace the existing traditional 6-year programme in 2006, as well as oversight of curriculum reform initiatives such as the introduction of "case-based learning" (Newman, 2003; Williams, 2005; Braeckman, Fieuw & Van Bogaert, 2008; Curran, Sharpe, Forristal & Flynn, 2008; Dupuis and Persky, 2008; Kuhne-Eversmann, Eversmann & Fischer, 2008) into the latter years of the existing 6-year program. The planning for this new program began in late 2002 and continued until the end of 2005, with the new curriculum commencing in 2006. I was given full autonomy to establish the various curriculum reform priorities my unit would support and I followed closely the pattern of other medical education units across Australia and the UK (Davis, Karunathilake & Harden, 2005). I met with as many of the key internal and external stakeholders as it was possible to schedule in the first three months of the role (October to December 2005), which set the scene for the three years of planning of the new curriculum that followed.

As Director of this unit my teaching responsibilities were limited and I therefore had sufficient time to lead a small team of academics who were tasked with reforming the

[1] Hereafter referred to as 'SoM' or 'the School'. The title 'Southern State' is fictitious.

[2] The AMC is an independent national standards body for medical education and training in Australia: http://www.amc.org.au/index.php/about-us-mainmenu-108

curriculum, some of whom had negotiated "informal" secondments to the newly formed Medical Education Unit to participate in the project (most secondments however were usually less than a day a week and rarely resulted in significantly reduced teaching commitments). These academics and myself I regarded as "change agents" (Havelock, 1971; Havelock, 1978; Havelock & Zlotolow, 1995) within the medical school.

A typical week for me involved chairing curriculum planning meetings, frequent face-to-face meetings with individual full time and part-time members of the medical school's academic staff (often around coffee breaks), as well as meetings with hospital-based teaching staff (most of whom were met after-hours to accommodate busy clinical work commitments) and networking with medical education colleagues across Australia.

When I commenced in this new role I was already acquainted with many of the staff in the medical school and in the affiliated teaching hospitals. I was a former graduate of the medical school (class of '88) and had undertaken much of my subsequent hospital and specialist training in Southern State. Although I had spent several years working in other parts of Australia (including other medical schools) I had also worked in several General Practice posts around the State, as well as working as a Director of Medical Services in three of the Southern State's public hospitals and was therefore very familiar with the training needs of junior doctors in the postgraduate sector as well as the involvement of hospital and community based clinicians in the teaching of medical students.

I had completed an MBA two years prior to commencing this new post and the year prior had finished my own postgraduate specialty training in Medical Administration and felt familiar with the relevant aspects of organisational change, particularly as this applied to the health care setting.

As I settled into the new position I became increasingly aware of the many challenges involved in implementing curriculum change in a medical school and the impact this has on staff, particularly those charged with the responsibility of implementing large-scale curriculum reform (Davis & White, 2002). The particular curriculum change at Southern State Medical School was occurring within the context of a parallel governance change – a process which had begun the year prior to my commencing this post, again in response to recommendations made in 2001 by the School's accrediting body the AMC.

During the first few months I spent many hours listening to the frustrations of teaching staff in SoM who were continually being assailed by requests to change – change the way they delivered their instruction such as more problem-based, small group learning and less didactic teaching (Des Marchais, Bureau, Dumais & Pigeon, 1992; Albanese & Mitchell, 1993; Bland, Starnaman, Harris, Henry & Hembroff, 2000; Colliver, 2000; Newman, 2003; Morrison, 2004; Sanson-Fisher and Lynagh, 2005) as well as change their approach to student assessment such as using only assessment measures which were known to be valid and reliable (Swartz, Colliver, Bardes et al., 1999; van der Vleuten, 2000; Wass, Van der Vleuten, Shatzer et al., 2001; van der Vleuten & Schuwirth, 2005). They were now also being asked (by me and the staff on the Medical Education Unit representing the new 5-year curriculum) to participate in the development of a radically different medical curriculum from the existing program which many of the staff had grown accustomed to and which was now in its 38th year.

These issues have particular relevance as medical schools around Australia and internationally grapple with changing the way we approach the training of doctors. In designing a medical curriculum, medical educators are faced with how best to take account of rapid changes and advances in health care. For example, there is the exponential increase in the knowledge base underpinning medical practice, the exponential increase in the range of medical therapies, the need for cost effectiveness, the increasing awareness of the risk and cost to society of medical therapies, the recognized effectiveness and efficiency of interdisciplinary approaches to research and the development of population and disease-based centres (bringing together outstanding clinicians and researchers to achieve specific goals). The importance of the ambulatory care setting in medical education is also more recently acknowledged for the teaching role it can fill as it is increasingly recognized that with shorter hospital stays the norm, teaching hospitals may not be the ideal training ground they once were for our future doctors (Association of American Medical Colleges, 1984; World Health Organisation, 1991; Seifer, 1998; Xu, Hojat, Volaski et al., 1999; Genn, 2001 (a); Genn, 2001 (b); O'Connell & Pascoe, 2004).

My role within the school afforded me the unique opportunity to carefully reflect on my own perspectives of curriculum change and to work alongside a small team of highly committed teachers and education reformists who shared their perspectives with me along this journey. Over the course of the three years of guiding, facilitating and leading curriculum reform in this medical school I became increasingly aware of how complex change is, particularly in a medical school as it seeks to adopt world's best practice in curriculum matters. I also became aware of my own response and reactions to the change process and of the many tensions I experienced when the theoretical perspectives I had acquired collided abruptly with lived experience of change. During the course of the study I also witnessed the many contradictions that coexisted within the team of change agents around me and how individual perspectives including my own were continually challenged and tested by new events over the course of the three-year reform project.

I collected all the documentation we generated over the three-year curriculum planning period – the minutes of every meeting, the presentations we delivered, the school forums we facilitated, the significant electronic correspondence generated, the feedback from all our stakeholders including the AMC and the media stories that related to the project during this time frame. In addition through the use of semi-structured interviews I recorded the perspectives of the team working with me on this project of curriculum reform. To capture my own perspectives I diarized what were for me personal "highlights" or significant events throughout the three years. Using all of these "data", I was able to create a chronological "photograph album" of the lived experience of significant curriculum reform in a medical school.

Southern State School of Medicine

The Southern State School of Medicine (SoM) is the only medical school for the entire State and is the most rural of medical schools in Australia. The School has a presence in all three regions of the State (North West, North and South) with the Southern

operations spread over two campuses (the city campus and the Sandy Cove campus), approximately 5 km apart. Over its 43-year history[3] SoM has contributed significantly to the State's medical workforce.

Until 2004, the School was the smallest medical school in Australia, with a resultant marginal resource and staffing base. Since 2003 the School size had grown steadily from graduating about 40 doctors per year up until that time to doubling that number in 2003 (87 students per year) and increasing to over 100 students in 2004 with a projected "steady state" numbers of 120 graduates per year expected in 2010. The increased student numbers since 2003 made the school of equivalent size with other medical schools in Australia. The commencement of the new 5-year curriculum in 2006 in parallel with the roll-out of the "old" 6-year program contributed significantly to growth in student numbers.

The History of the School

The School was officially opened in 1965, although the decision to start a medical school had been on the agenda for some time. In March 1957 Mr. David Turnbull, MHA wrote to the then Vice Chancellor of the University of Southern State (Archives, 1957) pointing out the urgent necessity of creating a Medical Faculty and inviting him to a meeting to discuss the way forward. In his letter to the Vice Chancellor Turnbull wrote:

> From the State's point of view, the only chance for Southern State students to take up medicine as a career is either to matriculate at a Melbourne school when he (sic) has a very small chance of getting into the ten vacancies allotted to non-Victorian students or he has to go to Queensland.

Later that year at a University meeting of the Committee on the proposed medical school (Archives, 1957) the minutes record:

> As the main overcrowding at the University of Melbourne appeared to be in the pre-clinical years, the Committee discussed the possibility of establishing only a

[3] 2005, the final year of the curriculum planning process, marked the 40th anniversary since the School's founding,

> Pre-Clinical School in Southern State. The reports from Western Australia, however, strongly recommended the establishment of a full School, suggesting that teachers of the necessary calibre might not be found if only a Pre-Clinical School were established. Members of the Committee agreed, too, that there was sufficient quantity and diversity of clinical material in Southern State, especially if the [other] hospitals were both used. The Committee agreed that on the basis of these two factors a full Medical School was the solution to the State's need.

A Select committee was convened two years later which considered various reports and interviewed several prominent members of the medical and academic community before handing down its decision in November 1959, unanimously recommending immediate plans be made to "bring this scheme into fruition", with the first graduates expected in 1970 (Archives, 1959). The medical program was initially accredited by the General Medical Council in the UK and commenced in 1965 as a traditional 6-year medical degree program and graduating approximately 40 doctors per year. The curriculum in this medical school (which I can confirm as a student of the program between 1982 and 1988) conformed largely to Bloom's description of medical education in the 20th century. The initial phase of the program (first two and a half years) confined largely to teaching in the basic sciences with regularly scheduled days in the dissection rooms and laboratories during which students were "expected to master... a huge mass of knowledge about anatomy, physiology, biochemistry, microbiology, pathology, pharmacology and related sub disciplines... an experience dominated by memorization and didactic teaching" (Bloom, 1989, p. 230). The second phase, the clinical years, were designed along the lines of experiential learning at the bedside, with regular supervised time spent with patients in the clinics and hospitals.

Over the course of the next four decades, the curriculum at the SoM evolved with incremental small scale reform only. In my discussions with former Deans these changes were mainly attempts to improve the level of integration between the first few years teaching in the basic sciences and the clinical years spent at the bedside. According to the current Dean, who by 2005 had spent 18 years at the School, none of these incremental reforms represented significant or enduring change for the curriculum, hence in part the decision taken in 2002 to radically overhaul the curriculum by introducing a "brand new" better integrated and shorter (5-year as opposed to 6-year) medical curriculum (with an altered governance structure to support the change). This

new curriculum provided the unique opportunity, as I saw it, to "start afresh" and permit careful scrutiny as to whether the old curriculum really was adopting world's best practice in content and delivery and how well therefore it was preparing its graduates for their future careers in a rapidly changing world of health care delivery (Hill, Rolfe, Pearson et al., 1998; Langdale, Schaad, Wipf et al., 2003; MacCarrick, Winzenberg, Holloway et al., 2005; MacCarrick, Bradford, Vial et al., 2007). The decision to introduce a new curriculum also allowed the school to respond more comprehensively to the persistent recommendations made by the AMC over the previous decade about aspects of curriculum delivery including the need to improve the level of integration of the basic and clinical sciences in the old curriculum (Australian Medical Council, 2001).

Southern State School of Medicine Accreditation and the Australian Medical Council

The SoM was first accredited by the AMC in 1991. Under its accreditation guidelines, the AMC has several courses of action it can take upon deciding whether a particular medical school has (or has not) met the national standards[4]:

(a) Accreditation could be awarded for the maximum period[5], with or without conditions,

(b) Accreditation could be awarded for a shorter period of time where significant deficiencies were identified, or

(c) Accreditation could be refused where the AMC considered that the deficiencies were so serious as to warrant that action.

From the time the SoM was first accredited by the AMC, the relationship had been a difficult one with a series of less than favourable accreditation reports from the AMC in the decade that followed. As a consequence, the SoM was sometimes portrayed by the

[4] http://www.amc.org.au/images/Medschool/Part3toCouncil06-08.pdf

[5] An established medical school may be granted a maximum period of six years' accreditation in the first instance. On the recommendation of the Medical School Accreditation Committee (MEDSAC), the Council may grant a further four years of accreditation, subject to a satisfactory report by the school in the fifth year of accreditation.

local media as having a precarious future, with numerous media reports touting potential closure in the mid 90s. During this period, the local newspaper, *The Mercury*, ran several stories relating to the School's struggle to survive:

> Over the past few months there have been threats to the number of graduates and the smaller [medical] schools... The state president of the AMA, Dr Brendan Nelson, said yesterday the school's future had been of great concern to medical practitioners throughout the state... Mr Howe is believed to be planning to reduce the intake of students to Australian medical schools in an attempt to reduce the country's over-supply of doctors, especially in city areas... A report in The Australian this week speculated that the viability of the medical schools at the University of Southern State, the University of Newcastle and Flinders University was threatened... Professor Gilbert said, "I believe that where there's smoke, there's a bit of fire. Over the past few months there have been threats to the number of graduates and the smaller [medical] schools. They gave us good reason to worry." Professor Gilbert said Southern State's need for its own medical school was very different to other states because it was largely a rural state. (*The Mercury*, 7th March, 1992)

Three years later...

> Although the political threat to the school of medicine...has eased, the fate of the institute still hangs in the balance....If those entrusted with reaccrediting the school believe that the medical colleges lack confidence in the University of Southern State's ability to run the school, then they may well decide that it should be denied accreditation, which would cause its closure. (*The Mercury*, 13th June, 1995)

In the School's 1996 accreditation report, not all conditions stipulated by the AMC the previous year were satisfied and a return visit was made to the School in October 1998. The 1998 team again recommended that accreditation only be granted for a limited time subject to receipt of satisfactory annual reports demonstrating continuing progress in specific areas. The course was next assessed in 2001 and the report on that occasion again identified "significant challenges to further appropriate reform and recurring themes that must be addressed and resolved urgently" (Australian Medical Council, 2001, p. 43).

The 2001 AMC Report to the School was critical, drawing attention to the School's need for "collective will" to introduce the required curriculum reforms. The AMC disagreed with the School's view that it (SoM) would "never have the resources for a centrally

developed curriculum" (Australian Medical Council, 2001, p. 9), going on to advise the School that:

> While curriculum development does require significant resources, it could well be argued that this is not a question of resources, but rather of the collective will of the School. This is an issue of almost overriding importance that must be urgently addressed by the School in order to make the kinds of changes that are needed.

The 2001 AMC Accreditation Report recommended that accreditation of the School be extended for one year only, that is, until 31 December 2002, and required that the School report to the AMC on its "detailed and prioritized plans" to address in the short, medium and long term, issues relating to management, curriculum and staffing.

In response to this the Dean and executive of SoM decided in 2002 to radically alter the traditional six-year medical degree course to a five-year program. In support of this, a Medical Education Unit was established for the first time at SoM. The plan was to commence the new program in 2005. The AMC concurred in principle with the decision to reform the curriculum, adding however, given the School's particular resource constraints, that deferral of commencement of the new program until 2006 should be considered. The School agreed with the recommendation and at the November 2002 meeting of the AMC, SoM received an extension of its accreditation for the three years to December 2005 to cover the requisite planning phase. There were however a series of strict caveats, namely that the School submit annual reports against the existing 6-year program (which was being rolled out for the last time[6]) and that regular submissions be made on progress towards the development of the new curriculum, namely a Preliminary Report and Stage 1 and Stage 2 Reports.

At the June 2004 meeting of the AMC's Medical School Accreditation Committee, the Stage 1 submission for the new five-year course was considered and received favourable endorsement and the SoM was permitted to continue to the next stage of curriculum

[6] The temporal relationship between the old 6-year curriculum and the new 5-year curriculum was such that 2005 was scheduled to represent the last intake of students into the old 6-year curriculum, pending successful accreditation of the new course. This would see the first cohort of 5–year curriculum graduates and the last cohort of 6–year curriculum graduates complete their studies together in 2010.

planning. The AMC nominated, in consultation with the School, a panel of eight to form an accreditation team for the School. The team consisted of three Deans, two heads of academic departments from other Australian medical schools, two medical advisors of Australian postgraduate medical training organizations and a representative from the AMC. The Stage 2 (final) submission was received by AMC Medical School Accreditation Committee (MEDSAC) in January 2005, and over the ensuing six months was carefully perused by the accreditation panel with numerous requests for additional information or clarification directed to either the Dean or myself during that time. Subsequently this team conducted an official site visit to inspect the School and discuss the plans for the new five-year curriculum during a week long visit in May 2005. Six months later, in November 2005, the AMC handed down its decision.

Internal Factors

New governance arrangements

During the period of this study, apart from the proposed reform of the medical curriculum, the medical school itself was undergoing a governance restructure. This saw a move away from a traditional discipline-based structure to one which reflected the desired better integration of teaching and learning but also the school's medical research activities. For instance whilst in the past departmental-based governance was the norm this served only to reinforce departmental identity, and did not encourage cooperation across disciplines (Reynolds, Adler, Kanter et al., 1995). The Dean of SoM at the time (in 2002) wanted the School to adopt the trend in other newer Australian medical schools which had moved away from departmental-based governance to centralized governance (Lawson, Chew & Van Der Weyden, 2004) where the students' educational experience is organized around *what is taught* not according to departmental structures (Davis & White, 2002).

During the course of this study, apart from being urged to participate in the planning for the new curriculum, many staff found themselves adjusting to a move away from belonging to discipline-based departments to belonging to year groups, i.e. identifying with the staff who taught in the same year of the curriculum they taught in. This had the

advantage that staff were forced to move outside their discipline and become familiar with aspects of the curriculum they were not previously exposed to. I saw this as the ideal context in which to plan a better integrated new five-year medical program.

Relocation to city centre

Another decision taken by the University which had an impact on staff of the medical school during the course of the study was a decision to provide a substantial new building for the SoM in the city centre. The University Council approved a total development of approximately $40 million in 2004, which was to incorporate a new medical school building proximate to the main teaching hospital, which was to house the SoM and the neighboring prestigious medical research institute, the Southern State Research Institute. This new development was also to entail refurbishment of the existing buildings and the redevelopment of the Medical Sciences building on the Sandy Cove Campus. The proposed new building was to provide additional space for the expanded numbers of students studying medicine in Southern State. The co-location plans were also designed to encourage greater integration and cooperation between clinical medicine and medical research in Southern State.

Some of the School's teaching spaces had been upgraded to cope with the gradually increasing student numbers. Facilities were expected to be considerably stretched during the period 2005–2007 until the new buildings were opened, creating significant anxiety for those responsible for timetabling and planning. Added to this, the proposed new teaching model for the new curriculum, which was to emphasize small group teaching, required space for no more than 10–15 students at a time. This would require significant changes to existing space configuration to permit greater flexibility in use of teaching space in the future. The new 5-year curriculum also proposed a stronger focus on self-directed learning, and as a consequence some of the technology needed to be upgraded to facilitate this mode of learning.

Although all the building plans were not scheduled to be complete until the first semester of 2007, a number of working groups were established to determine what parts of the program would be relocated to the city centre and which were to remain where

they were presently located. These considerations often impacted on planning for the new curriculum as the exact location of delivery of some parts of the curriculum remained unknown until weeks before the implementation of the new program.

Increasing student numbers

Over most of its 39 year history (until 2004) the School was the smallest medical school in Australia. Since the late 1980s, however, there had been a slow growth in numbers to about 60 graduates per year and by 2004 this increased to over 80 students per year and subsequently to over 100 students, with a projected 'steady state' numbers of 120 graduates per year expected in 2010. The increased student numbers largely since 2003 made the school of equivalent size with other medical schools in Australia. 2003 was a significant year for the SoM as it was the year the Australian Government allocated an additional 234 places to be shared amongst all the Australian medical schools in recognition of the medical workforce shortage. As part of this national allocation of funding, SoM was granted an additional 21 domestic student places for its 2004 intake. The government also identified at that time that a minimum number of places (80) was appropriate to sustain a medical school and, as a result, nearly 10% of the 2004 total national increase in medical student numbers went to Southern State, taking its numbers to 83.

The target enrolment figures for the last year intake of the old curriculum in 2005 and the first year intake of the new curriculum in 2006 was 55. These figures were based on the need for reduced intake for these years in order not to exceed the projected maximum capacity of clinical placements (in the hospitals around the State) in the years when both courses would overlap (2009-2010).

In summary, all of these internal factors contributed to the complexity of the work environment for staff at SoM. Faced not only with the prospect of having to embrace a new shorter medical curriculum, with altered delivery styles and assessment as well as in some cases altered content driven by outcomes, there was also the impact of increased student numbers and the prospect of a relocation to the city centre adding to the general level of uncertainty in the workplace.

It was in the midst of this context of continual change that the planning for the new curriculum took place.

External Factors

Medical education in Australia

Medical education reform is not a recent phenomenon in Australia (Brooks, Doherty & Donald, 2001). One of the landmark attempts to establish a completely new approach to the teaching of medical students in Australia was the Newcastle curriculum, introduced in 1978 (Engel & Clarke, 1979). Newcastle developed a curriculum based on content (objectives) and process (problem-based learning) and used a team approach to developing the overarching outcomes. The approach to curriculum design was described as follows by the Foundation Associate Professor of Medical Education at the University of Newcastle:

> The Dean and a small number of foundation professors attempted to answer the first question – What constitutes a general preparation for further study? – by defining the competencies that students should demonstrate prior to graduation... In some instances it was thought that merely the *ability* to do something would not be sufficient and that the student should also be expected to demonstrate his *willingness* to apply stipulated knowledge, understanding, skills and attitudes. (Engel & Clarke, 1979, p. 70)

Beginning with 45 general statements of intent, the curriculum planners for each part of the new medical course generated more specific objectives which were consistent with the overarching program objectives and which described the competence of the student at the end of each particular period of study. The particular underpinnings of the new medical program were better integration of the basic and clinical sciences; small-group learning; independent and self-directed learning and problem-based learning (PBL) (Kaufman, 1985; Morrison, 2004). The University of Newcastle not only led a major change in medical education in Australia in the late 1970s by introducing this problem-based curriculum, they had also been very progressive by introducing personal qualities evaluation to the student selection process (Powis, 2008).

During the period of this study, the field of medical education in Australia was particularly active, undergoing what the AMC described as "a period of unprecedented change... fostered by an increased collaboration and better cross fertilisation of ideas between the different medical schools across Australia" (Australian Medical Council, 2005). Some of the trends in other Australian medical schools which informed curriculum planning at SoM at the time included greater focus on increasing the breadth of students' clinical experience beginning from the first year of the program, more emphasis on communication skills training, and more emphasis on student-directed learning. In 2004, seven new Australian medical schools were at various stages of development – each school distinct from the other. As described by Lawson, Chew and Van Der Weyden (2004):

> These differences lie not in their curricula and courses, which incorporate many recent reforms of medical education, but in the ways the new schools are structuring themselves and harnessing resources for delivering the curriculum, as well as in their priorities and the specific qualities they wish to foster in their graduates. (p. 662)

Some of the new and emerging issues faced by medical schools in Australia included the recognized need to be more student centered, delivering adaptive curricula which incorporated the latest teaching innovations, commitment to ensuring fitness to practice and commitment to the medical education research agenda (Young & Wilkinson, 2005). Two key factors which influenced Australian medical education during the time frame of this study included the findings of the 2005 Productivity Commission's report on Australia's health workforce and an inaugural national conference on medical education in Australia sponsored by the Committee of Deans of Australian Medical Schools and the Australian Medical Council held in 2005. The Productivity Commission's Report highlighted the need for more responsive education and training across the continuum of medical education, i.e. from under graduate to post graduate (Australian Government Productivity Commission, 2005). The conference entitled "Medical Education Towards 2010: Shared Visions and Common Goals" was the first of its kind in Australian medical education, reflecting the fundamental role of medical education in providing and shaping the future medical workforce. Over 170 delegates and speakers participated, representing a broad range of major stakeholder groups and organizations in medical education in the region. Nineteen medical schools, including SoM, were represented

from not only Australia, but New Zealand, and Fiji. One of the key outcomes of this conference was greater awareness amongst individual and organizational stakeholders of the intrinsic linkages between the different stages in medical education, training and practice (CDAMS & AMC, 2005).

Across the broader medical community, a key debate in medical education in Australia was also occurring during the time frame of this study and related to concerns about the training of doctors in universities. Many medical practitioners began to question whether the move to better integrated and problem-based curricula was sacrificing important content in the basic sciences (Australian Doctors Fund, 2005). In response to the debate, the then Minister for Education, Science and Training, commissioned a study to address the question "What makes for success in medical education?" The study was first proposed by Minister Nelson in an address to the Australian Doctors' Fund (ADF) on 18th of February 2005. Some of the controversial issues raised at that Forum included whether medical education in Australia was in crisis, and if so, who and what was responsible; whether medical schools were downgrading basic sciences and whether Australia's teaching hospitals were failing medical students by not providing adequate training. The ADF called on the Deans of medical schools in Australia and those involved in curriculum development to ensure that all medical students receive a "comprehensive practical education in anatomy, physiology, microbiology, biochemistry, pharmacology and pathology as an essential requirement and foundation of their medical education and hence reverse the downgrading of these basic medical sciences". The ADF also called on the Deans to ensure that all medical students received the "proper balance between medical and social science, theory and practice, didactic teaching and problem-based learning" (Australian Doctors Fund, 2005).

Medical education internationally

When I commenced this study, I looked back in time at the literature on curriculum reform over the previous three decades and found a number of studies which described the results of significant curriculum reform in international settings (Kaufman, Mennin, Waterman et al., 1989; Neufeld, Woodward & McLeod, 1989; Grand'Maison and Des Marchais, 1991; Towle & Jolly, 1998). More recently and around the time we were planning the new medical curriculum at SoM, there were further significant international

medical education developments which informed my own thinking about curriculum content and delivery.

Between 1997 and 2002, the implementation phase of the Canadian Medical Education Directions for Specialists (Frank & Langer , 2003; Frank & Danoff, 2007, CanMEDS, 1996) project was occurring. This innovative project, sponsored by the Royal College of Physicians and Surgeons of Canada Health and Public Policy Committee, saw a shift toward competency and outcome-based medical education. The underlying premise of the CanMEDS model was that doctors ought be required to demonstrate proficiency in seven domains which were: 1) Medical Expert (the central role), 2) Professional, 3) Health Advocate, 4) Scholar, 5) Manager, 6) Collaborator, and 7) Communicator. Also around this time the General Medical Council (GMC) of the UK had published *Good Medical Practice* in May 2001, the principles of which made clear to the public the standards of practice and care they should expect from their doctors. In an earlier publication, *Tomorrow's doctors,* first published in 1993 (General Medical Council, 2008), the GMC had articulated its position on undergraduate medical education signaling a significant change in focus in medical education from gaining knowledge to a learning process that included the ability to evaluate data as well as developing skills to interact effectively with patients and colleagues. During this time medical schools in the UK were responding to the GMC guidelines with new, ground-breaking medical curricula.

Given the exciting developments in medical education nationally and internationally and the increasing complexity of educational and organizational processes in modern medical education, I felt there was a need to better understand how curriculum change is experienced and incorporated into everyday practice. Presented with the unique opportunity to lead major reform at the medical school in which I trained I felt I could enhance existing theoretical understanding of curriculum change in medical education by exploring the lived experience of that change by senior staff.

Summary

Against this backdrop of rapid and exciting change in medical education nationally (seven new medical schools were at various stages of development in Australia by 2004) and internationally, SoM was planning its own new 5-year outcomes-focused, case-based medical curriculum. In addition the school was preparing for further increases in student numbers and relocation of many of its core teaching activities to the city centre and had made significant alterations to the school's governance structures in an effort to reverse the traditional discipline based organization of teaching to an improved integrated model of delivery.

I felt a need to better understand how significant curriculum change such as this is experienced in a medical school. In particular I felt drawn to a better understanding of the lived experience of curriculum change, as I was experiencing it and as those close to the curriculum reform planning process were experiencing it.

This study is located in the three-year curriculum planning period from the end of 2002 to the end of 2005, leading up to the decision by the AMC to permit a new 5-year medical curriculum to commence in Southern State, replacing the old 6-year traditional program.

Chapter 2 – Positioning the Study: Curriculum Reform, Narrative, and Organizational Change

Research Origins

Researcher Origins

For many years I had enjoyed a professional interest in medical education. My career up to the point of accepting this new academic appointment had always had a strong connection with the training of doctors at both an undergraduate and postgraduate level. Ever since my own General Practice training years in the early 90s I had taught medical students. After obtaining Fellowships in General Practice and Rural and Remote Medicine I joined the General Practice Training Program (formerly called the Family Medicine Program). This program was at the time at the forefront in Australia developing a national curriculum. Curriculum documents informed by medical practitioners from a variety of disciplines working in partnerships with educationalists were being generated around Australia in support of this endeavour. These included curriculum outcomes relating to Australia's rural and indigenous health (Smith & Wellard, 1996; Prideaux & Smith, 1999; Worley, Silagy & Prideaux et al., 2000). During this time I developed a particular interest in the measurement of clinical competence and assessment of medical practitioners in the "real" clinical setting (Hays & Wellard, 1998; Spike, Alexander, Elliott et al., 2000) as distinct from the arguably less authentic assessment undertaken in structured objective examination settings (Harden, 1988; Harden, 1990). I coordinated Southern State's first "In-Training Assessment" pilot project as part of my brief as a medical educator with the RACGP Training Program in 1998, which has since been refined in recent years with trainees now required to compile comprehensive portfolios of evidence of clinical competence during their "on the job" training. I found medical education then exciting and dynamic with new approaches to curriculum delivery and assessment emerging all the time. Although my own undergraduate training had conformed to a traditional model I was keen to embrace the new changes in my own sphere of influence, whether that was teaching medical students or post-graduate training. During the late 90s in my post-

graduate trainer roles I experimented with simulated patients (Vu, Marcy, Colliver et al., 1992), computer-assisted learning (Piemme, 1988), video-recording of communication skills and interview technique (Hays, Jones, Adkins et al., 1990) and In Training assessment (Hays & Wellard, 1998).

By the late 90s I began to pursue another passion – organizational behaviour. I had spent ten years as a serving member of the Royal Australian Air Force and witnessed what it was like to be part of a large organization. I had always been fascinated by how individuals within organizations contend with organizational change. Subsequent years spent in various health organizations in primary and tertiary settings, in posts both clinical and administrative, had made me aware of the impact of reforms in the workplace. I began a Masters in Business Administration in 1998 which then led to my pursuing specialist training in Medical Administration with the Australasian College of Medical Administrators and in 2000 I embarked on a full-time career in Hospital Administration. Instead of direct patient care I found myself immersed in specialist recruitment, chairing committees, writing hospital policies and guidelines and dealing with hospital patient grievances and staff performance appraisals. Returning as an Administrator to the hospital where I had served my internship and residency over a decade earlier, I found the changes quite staggering. On an almost weekly basis new technologies were being discussed and the exponential increase in the range (and cost) of medical therapies available to medical staff in hospitals was ever present. There were also significant changes to case-mix (Degeling, Black, Palmer et al., 1996) with much shorter lengths of hospital stay, a more informed public with changing expectations (Abelson & Lomas, 1996) and an increasing awareness of the risk and cost to society of medical error (Wilson, Runciman, Gibberd et al., 1995) – to name a few. All of these factors contributed to a continually changing landscape for the medical profession and importantly the training needs of future health care professionals.

I began to appreciate the imperative for medical curricula to reflect the changes occurring in practice. Was the modern day medical graduate "fit for purpose"? Were we doing all we could to prepare him/her for their future roles in a continually changing landscape? (AAMC, 1984) Although no longer involved in direct clinical care, I was

still drawn to the needs of trainee doctors and became heavily involved in junior doctor training in the hospitals in which I worked. Even though the interests of teaching junior doctors were at times at odds with the service provision role (Wartman, O'Sullivan & Cyr, 1990) I was keen to ensure I played my part in ensuring dedicated and quarantined time for hospital based junior doctors to engage in continuing professional development.

It was this passion for medical education that brought me to the attention of colleagues in Southern State medical school in which I had trained. When the post was advertised I wasted no time submitting my application.

Establishing a Medical Education Presence

The opportunity to establish the foundation Medical Education Unit and lead the development of a reinvigorated and shorter medical degree course at my own alma mater was an exciting personal and professional opportunity. It was a project I felt well equipped to manage and which promised to utilize the full extent of the knowledge and skills I had acquired in my previous medical and administrative training. This would provide an opportunity to develop a new medical curriculum that reflected modern day medicine and embraced best practice in medical education.

I felt privileged to have been given the opportunity to participate in this landmark journey of unprecedented reform in the School's history. From the first days there was for me a "sense of occasion" about the project. Within a month of starting I explored research opportunities as I felt strongly that this "journey" needed to be recorded and documented in a manner which would give a human voice to the endeavour as well as contribute to an understanding of change management in medical education.

A Vision for Change

I began my role with many ideas about a vision for the new curriculum. I was aware of all of the major reviews of undergraduate medical education undertaken since the

Flexner Report of 1910 (Flexner, 1910). This report had set the trend for the next century, which saw increased emphasis on the sciences basic to medicine with more time spent in laboratory-based studies as a precursor to the time spent by students in the clinical arena. For the following 60 years most medical schools, including my own, had conformed to a pattern of delivery which was two to four years of university-based teaching of the basic sciences followed by a two- to three-year period of clinical education with attachments rotating through a variety of clinical departments and units within hospitals.

The most significant challenge to the Flexner model came in 1984 from the Association of American Medical Colleges report on Physicians for the 21st century (AAMC, 1984). Amongst its recommendations was the need to better integrate basic science and clinical education to enhance learning of the sciences basic to medicine and to promote their appropriate application in the clinical setting. It was proposed the improved integration of the basic and clinical sciences would overcome the "artificial divide" between the scientific teaching in the so called "pre-clinical" years and bedside teaching in hospitals in the clinical years of the program (Bloom, 1995; Jolly & Rees, 1998). This artificial separation between what Jolly and Rees describe as the "enforced separation" between "the university-structured, subject-based introduction to scientific method and a patient-oriented, almost totally hospital-based, immersion in clinical practice" (p. 22) was increasingly criticized for not preparing medical graduates for their future practice. Many medical educators now long held the view that the traditional medical school experience did not adequately prepare doctors to attend to the "whole" person and to the psychological needs of patients or to the health care needs of communities they would serve and recommended significant curriculum reform (Kaufman, 1985; Kaufman, Mennin, Waterman et al., 1989; Cuban, 1990; World Health Organisation, 1991; Des Marchais, Bureau, Dumais et al., 1992; Cohen, Dannefer, Seidel et al., 1994; Cuban, 1997; Mennin & Krackov, 1998; Bland, Starnaman, Harris et al., 2000). The recommended reforms were towards a learner-centred model best described by Bloom (1989) who described the purpose of this "new" direction in medical education as to:

> redirect medical education towards an experiential, learner-centered model that will enable doctors to be both life-long learners of rapidly changing medical science and practitioners with the knowledge and skills available

> to equate the psychosocial with the biological aspects of medical care. (p. 237)

The AAMC Report (1984) also called for improved interdepartmental organization within medical schools to enable a coherent vision for the curriculum. Medical School deans were urged to encourage interdisciplinary and interdepartmental cooperation in design, delivery and evaluation of the curriculum in order that "a coherent and comprehensive educational program for medical students" might be delivered (p. 20). In addition then to reform of the curriculum content, reform of the governance structures to support curriculum reform were also being advocated.

Prior to the AAMC report, numerous other reports recommending the need for reform in medical education had emerged throughout the 20th century. Christakis (1995) reviewed 19 of 24 such reports published between 1910 and 1993, all calling for reform. As early as 1940, Weiskotten and colleagues (Weiskotten, Schwitalia, Cutter et al., 1940) highlighted the need for continuous dialogue between the departments within a medical school:

> As a professional institution the medical school considers its curriculum as a unified whole. The organization of the faculty into the various departments and the laying down of a more or less formal curriculum does not imply the independence of the several units. The continued visualization of objectives and the conduct of the educational program as a whole requires frequent departmental, interdepartmental and faculty conferences. (p. 81)

In addition to improved integration between the basic and clinical sciences reflected in improved interdepartmental cooperation, my own personal vision for the new curriculum was that its design stage should bring together interdepartmental expertise so that this might be reflected in the subsequent delivery of the curriculum. My other personal vision was that the curriculum be transparent to students and staff, and that the links between the desired knowledge, skills, and attitudes at the end of the program and the teaching and learning strategies to deliver this were made explicit to students (Biggs, 2003; Harden, 2007; Harden, 2007 (a); Harden, 2007 (b)). In part this desire for transparency was driven by my own experience of undergraduate medical education. During my 7-year undergraduate training at the SoM (which included a full honours year in medical research) I felt it had never been made clear to me as a student what I was

expected to acquire from each component of the course or how my performance would be assessed. This new curriculum project would provide an ideal opportunity to help design a course that would be open and transparent to students and staff and "constructively aligned"(Biggs, 2003):

> In aligned teaching, there is maximum consistency throughout the system. The curriculum is stated in the form of clear objectives, which state the level of understanding required rather than simply a list of topics to be covered. The teaching methods are chosen that are likely to realise these objectives...the assessment tasks address the objectives... students are "entrapped" in this web of consistency. (p. 27)

I was aware of the move towards competency-based curricula and ensuring graduates were ''fit for purpose'' which I sought to replicate at SoM. This focus had been likened to the impact of the Flexner Report a century ago (Carraccio, Wolfsthal, Englander et al., 2002). Caraccio and colleagues (2002) described the paradigm shift "from the current structure-and process-based curriculum to a competency-based curriculum and evaluation of outcomes" as the "Flexnerian revolution of the 21st century."(p. 361).

I was also aware of the shift towards outcomes based approaches to curriculum development (Frank & Danoff, 2007). Such an approach by beginning "with the end in mind" (Frank & Danoff, p. 643) I felt would allow us to step back from the existing program and carefully consider what specific knowledge and competencies were needed by our graduates at the end of their training to practice safely and importantly to "meet the needs of those they serve" (Frank & Danoff, 2007, p. 643).

One of the key areas I was keen the new curriculum would focus on was communication and collaboration skills as I had seen the consequences of poor communication skills repeatedly during my time as a director of hospital services (Makoul, 2003; von Fragstein, Silverman Cushing et al., 2008).

I also wanted the learning to be pertinent and interesting with greater utilization of clinically relevant cases delivered by enthusiastic practitioners to inspire the students' learning. These proposed changes to the new curriculum I felt were all in line with national and international trends (Barrows & Tamblyn, 1980; Neufeld, Woodward &

MCLeod, 1989; Norman, Schmidt, Albanese et al., 1992; Albanese & Mitchell, 1993; Vernon and Blake, 1993; Colliver, 2000; Norman and Schmidt, 2000). One of the key questions however was whether to embrace wholly or in part "problem-based learning" (PBL) as a number of the newer medical schools in Australia had done (Lawson, Chew & Van Der Weyden, 2004). PBL had been developed at McMaster in the late 1960s, driven, as Norman describes (Norman, 2002) by a desire to "construct a medical school that was more humane than one that used the traditional, lecture based approach" (p. 1560). I was aware of the significant body of literature about PBL (Neufeld & Barrows, 1974; Barrows & Tamblyn, 1980; Norman, Schmidt, Albanese et al., 1992; Norman & Schmidt, 2000). PBL has been argued to better activate students' prior knowledge and has been described (Morrison, 2004) as helping students to understand new information and facilitate recall:

> Enabling students to discuss and add to new knowledge to aid their recall; and providing a context for learning to help students apply their knowledge to clinical problems. There is, thus, a theoretical basis for PBL which fits with other theories of learning such as adult learning theory. (p. 174)

Other proponents of PBL argue that it encourages greater understanding of the basic and clinical sciences (Barrows, 1986), that it improves retention and recall (Regehr & Norman, 1996) and that it encourages hypothetico-deductive reasoning[7] (Newble and Clarke, 1986).

I was however also aware of the significant challenges PBL posed to medical educators across the globe and was guarded about wholesale adoption of this resource intensive strategy at the SoM. I was also aware that the literature on *outcomes* associated with PBL approaches was mixed. Some reports suggested that students of a PBL curriculum are superior in knowledge retention but inferior in overall knowledge and competence when compared with students of traditional curricula (Norman, Schmidt, Albanese et al., 1992). Others had found that PBL students' attitudes, class attendance and mood were better than those of students in traditional teaching institutions (Albanese & Mitchell, 1993; Vernon & Blake, 1993). Some studies suggested that overall there was not the expected evidence of educational advantage of PBL given the resource-intensive nature

[7] This is a form of reasoning in which predictions deduced from a hypothesis are tested by empirical data.

of the approach (Colliver, 2000), claiming that there was no "convincing evidence that PBL improves knowledge base and clinical performance, at least not of the magnitude that would be expected given the resources required" (p. 259). Furthermore a pilot systematic review and meta-analysis on the effectiveness of problem-based learning (Newman, 2003) indicated that PBL students report greater satisfaction and employ more productive approaches to study. However, in terms of knowledge accumulation and practice-based outcomes, results were mixed. In summarizing the evidence to date, Sanson-Fisher and Lynagh (2005) conclude:

> It appears that the most consistently demonstrated advantage of the PBL approach is the personal satisfaction of medical students engaged in this form of learning and their superior interpersonal skills. The importance given to these aspects of the educational process is, perhaps, a matter of social and institutional values. One could speculate that a more enjoyable, formative educational experience may translate to a greater resilience when coping with potential difficulties in one's professional life. However, testing such a hypothesis would be difficult... Evidence that PBL curricula lead to greater retention and recall of information and a strengthening of hypothetico-deductive reasoning is not robust and is mostly absent from research findings. (p. 258)

Based on the literature and my discussions with other medical educators in Australia and New Zealand I was keen to propose that the SoM adopt a hybrid model referred to as "case-based learning" (Williams, 2005) which would still utilize clinically relevant cases (weekly or fortnightly) integrated into the overall student's program which would help illustrate important concepts and keep the learning relevant to the clinical setting.

In summary, having been immersed in the field of medical education for some years and read the literature, I felt confident I could work with the staff at SoM to plan a world-class curriculum. I was enthusiastic about an outcomes-based approach which likely reflected my personal view that the curriculum should be clearly "mapped" for students and staff and that there should be no ambiguity about what was expected of students at each stage of the course. I was also keen that newer pedagogical approaches should replace the heavily didactic parts of the existing curriculum; however I was guarded about wholesale adoption of problem-based learning. Furthermore, the national debate in the medical profession about potential downgrading of the basic medical sciences in the newer "innovative" medical programs made me cautious about recommending reforms

which might be criticized as too radical. My approach would be to recommend maintaining the strengths of the existing curriculum with the new and using, where possible, an evidence-based approach to curriculum reform at SoM.

Staff Development to Support Medical Education Change

From the beginning I accepted that my role would include providing staff in the medical school as well as the wider medical profession engaged in support of SoM with the relevant information so that pedagogical decisions might be informed by the latest medical education literature. I recognized the need for a staff development strategy to support the curriculum reform process and welcomed the decision by the Dean to establish a formal Medical Education Unit (of which I became its foundation Director) shortly after I commenced. This saw the appointment over three years of several part-time staff to support me in the role.

I knew that the educational support of teaching staff at the SoM in this current context of rapid change would be challenging. As Jolly (2002) points out "modifying a curriculum is likely to be difficult. Without faculty development it may well be impossible" (p. 945). Numerous descriptions of approaches to faculty development exist (Wilkerson & Irby, 1998; Bland, Seaquist, Pacala et al., 2002; Clark, Houston, Kolodner et al., 2004; Amin, Hoon Eng, Gwee et al., 2005; Dewey, Friedland, Richards et al., 2005). The predominant focus in medical education has been the teaching skills of busy clinical educators (Lowry, 1993; Lake & Vickery, 2006). Several impediments to faculty development in the medical education context have been described and include the lack of time available to busy clinicians to teach effectively as well as lack of knowledge about teaching, lack of training and lack of a reward system to encourage better teaching. To cope with these challenges, it is recognized that medical teachers need knowledge and skills (Wall & McAleer, 2000; Spencer, 2003) to teach effectively in the clinical setting where most teaching in hospitals is delivered "on the run" with patients on hospital ward rounds (Lake & Vickery, 2006). Whilst I recognized that factors such as time limitations would influence the sorts of staff development initiatives I offered, I nonetheless did not want "faculty development" to be interpreted narrowly as merely

attendance at workshops on teaching skills (Stritter & Hain, 1977; Stritter, 1983). Irby analyzed the teaching styles of six distinguished clinical teachers in an attempt to identify what clinical teachers needed to know and do to become effective (Irby, 1992; Irby, 1994). His work confirmed earlier findings (Jolly & Macdonald, 1989) that to be effective, clinical teachers need expertise not only in clinical teaching, but also in learning theory and evaluation. I structured the staff development strategy accordingly.

As new pedagogical approaches such as case-based learning were likely to be a significant part of the new medical curriculum, I saw the need for faculty development which focused on small group teaching with a clinical focus. In this regard SoM would be following a pattern seen in most other medical schools which had adopted new educational strategies (Jolly, 2002). Other medical schools which had also a long tradition of orthodoxy and were now embracing new approaches to curriculum delivery such as PBL invested in tailored staff development programs (Kaufman, Mennin, Waterman et al., 1989; Evans & Taylor, 1996) which invariably included theoretical explanations of PBL, small group discussion and construction of PBL problems (Jolly, 2002). At Sherbrooke medical school, for instance, the approach adopted was comprehensive and included a 2-day introductory workshop to initiate teachers into the educational principles and their application in the new program; a one-year basic training program in medical pedagogy; a one-day workshop on PBL; and a comprehensive three-day training program in PBL tutoring (Des Marchais, Jean & Delorme, 1990; Grand'Maison & Des Marchais, 1991). Although I recognized the overall importance of staff development at SoM as we embarked on this new enterprise, I doubted the School could mount such a comprehensive staff development initiative as this. I was uncertain however about the full extent of the resources that would be at my disposal and about the potential for growth in the area of medical education support. These factors would impact upon the extent of the staff development program that the newly formed Medical Education Unit might offer.

The Place of Medical Education Units

Across the world the coordination of the delivery of appropriate staff development in medical schools has increasingly become the realm of Departments of Medical Education (Albanese, Dottl & Nowacek, 2001; Davis, Karunathilake & Harden, 2005). Such departments are variously called Medical Education Units, Centre for Educational Research, Centre for Medical and Health Science Education or Centre for Educational Development and have becomes almost an essential requirement for a medical school (Davis, Karunathilake & Harden, 2005). Davis et al (2005) describe the establishment of Medical Education Units as responding to various pressures such as:

> increased public expectations relating to healthcare, which place increasing demands on healthcare professionals; societal trends towards increased accountability; educational developments that call for increased sophistication on the part of teachers in the health professions; the increased scope of and specialization within medicine that focus attention on what to teach and how to educate doctors; and the need to train more doctors within existing resources. (p. 665)

The functions of such departments include research, teaching and support of academic staff. Typically such departments help staff acquire skills in large and small group teaching, student assessment, curriculum development and evaluation and research in medical education. In parallel with this growth in interest in Medical Education Units is a corresponding trend to require medical teachers to undertake formal training in medical education. Jolly pointed out that the number of medical practitioners with a Masters degree in medical education is increasing (Jolly & Rees, 1998). Likewise, based on the current trend Harden predicted formal medical education training will be compulsory for medical teachers in the future, suggesting that we can expect to see an increasing number of appointments made in specialized aspects of medical education, such as medical student assessment (Harden, 1998). Once I became established in my role I contacted staff from the University's Flexible Education Unit (later became the Centre for Advancement of Learning and Teaching) whom I knew to be establishing a Graduate Certificate in Learning and Teaching for university staff of all disciplines to see whether it might be possible to influence the content of their program to meet the needs of the staff of SoM. The reception was excellent and in its first year six staff from the medical school had enrolled.

Albanese and colleagues found that a large number of Medical Education Units were associated with the Medical School Dean's office and close communication with a supportive dean was an essential part of the successful Medical Education Unit (Albanese, Dottl & Nowacek, 2001).The elements of successful leadership in higher education have been described (Ramsden, 2003) and the specific qualities of the "ideal" Director of the Medical Education Unit have likewise been articulated (Davis, Karunathilake & Harden, 2005):

> He/she should be in a position to foster scholarly habits among the staff... have a flair for teaching... a reputation for innovation... can convey a sense of excitement about teaching... who motivates people to do more than they ever thought that they could... sets a challenging climate for academic work and stimulates the lively exchange of ideas between colleagues. (p. 671)

Davis and colleagues also point out the need for the Director of the Medical Education Unit to foster career development and recognize the achievements of academic staff particularly given "the difficulties associated with rewards for teaching in most medical schools" (p. 671). In summarizing the role of the Medical Education Unit the essential activities should include teaching, research, service provision and nurturing the careers of staff. "Such a resource should be closely integrated with the faculty and seen as supportive to the faculty. It should not be seen as a separate entity from the faculty" (p. 674).

I was pleased by the decision to establish a small Medical Education Unit at the SoM, albeit financed by the Commonwealth government for a limited period of three years, and felt this augured well for the success of the curriculum reform initiative. I was also heartened by my offer of a place as a senior member of Faculty executive which managed the affairs of the Medical School and by the proposed placement of my office on the top floor of the medical school, two offices removed from the Dean's office.

Introducing Change at SoM

I began my new role as Director of the Medical Education Unit confident that with respect to introducing change most of the challenges I would encounter would be explained by reference to the literature on change I had read as part of my studies towards an MBA. I searched and found a substantial body of literature which examined

staff reaction to implementing large scale change in the education setting including the particular concerns of teachers (Fuller, 1969; Hall & Hord, 1987; Fullan, 1993; Fullan, 1999; Fullan, 2001 (a); Fullan, 2001 (b)). I also found useful guidance and insights from the literature on introducing curriculum reform in the context of the medical school (Bloom, 1973; Bloom, 1988; Bloom, 1989; Des Marchais, Bureau, Dumais et al., 1992; Bloom, 1995; Dannefer, Johnston & Krackov, 1998; Davis & Harden, 2003).

Shortly after commencing, however, I began to identify many unexpected and challenging aspects to the role. There were for instance vastly different ways in which individuals understood and interpreted the changes they were experiencing as part of curriculum and governance reform. I had been warned by some senior colleagues to expect a lot of "resistance" to change and not to expect too much support from certain "camps" and I found significant evidence of this in my early encounters with staff. Abrahamson (1996) had likened the phenomenon of changing a medical school curriculum to "had moving a graveyard", serving the same purpose as "rearranging the lifeboats on the Titanic" (p.128). My initial meetings with staff seemed to give credence to this analogy.

Increasingly I returned to the change literature for guidance. I found myself categorizing conversations I had with staff using for instance Rogers' taxonomy (Rogers, 1995 (a); Rogers, 1995 (b)). As I met with academic and clinical teachers, I mentally assigned them on the basis of their conversations with me about the proposed changes to one of the five categories Rogers described.[8] Making these mental notes allowed me to target my communication strategies and plan my coalition building activities so as to direct what soon became apparent to me as my limited resources. The terms *Late Majority* and *Laggards* were continually surfacing to the foreground of my mind when speaking to academics I had hoped would be the *Early Adopters* keen to try new ideas. Recognizing the need to take into account the local organizational climate (Genn, 2001 (a) & (b)) I made my own assessment of the culture at SoM in an attempt to diagnose and overcome any "institutional barriers to innovation" (Mennin & Kaufman, 1989). I became increasingly conscious of my own response to the escalating number of negative and

[8] (1) Innovators (2) Early Adopters (3) Early Majority (4) Late Majority and (5) Laggards

challenging perspectives I encountered. I quickly reasoned that a participative leadership style that enabled me to develop and build coalitions (Bland, Starnaman Hembroff et al., 1999) would best match the institution and the curriculum reform project at hand (Cohen, Dannefer, Seidel et al., 1994).

I saw the tasks ahead as manifold. Firstly there was the outstanding need to establish in the minds of staff in the medical school the "need" for change (Levine, 1980). Surprisingly this did not seem to have been addressed as most staff I spoke with after commencing the post seemed to be either opposed to or ambivalent about the need to reform the curriculum. Having established that need though, and with the Dean's support and that of senior faculty, I would then require the support of a team to help develop a new medical curriculum that would take into account the need for improved integration of the curriculum; greater emphasis on small group teaching; more reliable and valid assessment and greater focus on curriculum outcomes. Increasingly I began to see myself as a change agent (Havelock & Zlotolow, 1995) in search of other change agents to help me make this unprecedented reform of the medical curriculum a reality.

Although I had a clear vision for the new course based on best practice in medical education and recognized the unique opportunity this provided me to play a significant part in reforming my old medical school curriculum, the significant challenges I would face began to emerge. These included a significant lack of shared acceptance and understanding of the need to radically overhaul the medical curriculum. Some (including senior) academics felt that in the absence of evidence to support reform (for example, evidence to suggest SoM graduates were deficient), the existing curriculum should remain intact. Others felt a modest amount of change was all that was required – as one member of staff put it to me, "just enough change to bring ourselves into line with the AMC". Most academics I spoke to in the early months of the project did not understand the rationale for the decision to adopt a shorter and better integrated new program from 2006.

Already I could see the divide between my own perspective and those I was expected to work alongside. My role seemed clear to me and was to lead and coordinate the curriculum reform project resulting in a new medical curriculum at SoM by 2006, which embraced best practice in medical education and satisfied the AMC's concerns expressed in their 2001 report. Whilst the task seemed clear to me, it was not, it seemed, clear to others. Significantly the task ahead did not seem to be either accepted or understood by the majority of staff I encountered and I found myself confused at the outset about whose interests this project really served.

Deriving a Theoretical Framework for the Study

Change in Education

The more I reflected on my own dilemma and the more I spoke to teachers in SoM about their concerns the more I came to appreciate the complexity of educational reform in modern medical education. I felt there was an outstanding need to better understand how change is experienced by medical teachers and incorporated into everyday practice. Understanding and supporting the process of change effectively in medical schools seemed to me as important as assessing the outcomes of the educational reforms themselves.

I went back to the literature I was familiar with on organizational change and behaviour through my studies towards an MBA (Levine, 1980; Rogers, 1995; Luthans, 2005; Mullins, 2005) looking specifically for the literature which focused on explaining and predicting human behaviour within organizations such as Lewin's Force Field theory (Lewin & Cartwright, 1952), Bandura's social cognitive theory (Bandura, 1986) and Getzels and Guba's social system theory (Getzels & Guba, 1957). I also turned again to the literature on models of how change is successfully introduced into organizations. Rogers (1995) describes a two-step process consisting of firstly setting the change agenda and secondly implementing the change and making change routine (Rogers, 1995). Levine (1980) describes a four-stage process (1) recognizing the need for change, (2) planning, (3) implementing, and (4) institutionalizing change (Levine, 1980). I then turned again to the literature on change in education (Mort, 1958; Fuller, 1969;

Havelock, 1978; Hall & Hord, 1987; Waugh & Punch, 1987; Fullan & Hawker Brownlow Education, 1997; Fullan, 1999; Fullan, 2001; Fullan, 2001) which highlighted many years of research directed towards understanding the change process as experienced by educators and educational administrators. Havelock (1978), who worked extensively with teachers, identified six stages through which the individual who seeks to encourage adoption of a new innovation or "change facilitator" can encourage such adoption. These stages include (1) establishing a relationship with the change user, (2) diagnosing the problem, (3) acquiring relevant resources, (4) choosing an appropriate solution, (5) developing appropriate change facilitator diffusion strategies, and (6) stabilizing the innovation. Fuller (1969) described patterns of needs and interests on the part of teachers that differed based on the particular career stage they were at. For instance, teachers starting out in their professional careers were more concerned with themselves in the first instance, but as they became more experienced such issues were replaced with concerns about tasks or management or the impact of their teaching on students. Building on this framework, Hall and Hord (1987) expanded the original concerns model to include seven developmental stages or "Stages of Concern", which has since become part of a larger model of the change process referred to as the Concerns Based Adoption Model (Hall, 1979; Hall, 1985; Hall & Hord, 1987). Chauvin (2002) points out that attending to the full range of the Stages of Concern will maximize an organization's opportunity to learn, improve and respond to rapid change. The need to be *concerns-based* in my own leadership of this project resonated with me as I began to recognize staff in each department all at very different phases of their own careers – some nearing retirement, some recently recruited to SoM.

Change in Medical Education

I returned also to the literature on change in medical education as I continued to explore how to implement successful curriculum reform in the medical school setting. I recognized that change was not a new phenomenon in medical education and was therefore not surprised to find a significant body of work from the U.S. in particular which described approaches to managing curriculum change drawing on over 50 years of work of various commissions (Weiskotten, Schwitalia, Cutter et al., 1940; Deitrick &

Berson, 1953; AAMC, 1984; Marston & Jones, 1992). Change itself affects every aspect of an educational organization (Hoy & Miskel, 1986; Christakis, 1995; Cuban, 1997) whether it is incremental change (targeting refinements such as introducing a new module or a new form of teaching delivery) or more fundamental reform such as that which was planned for SoM.

I was aware of some of the barriers to reform in medical education such as the desire on the part of medical teachers to maintain stability in their professional work and retreating therefore to traditional ways of teaching (Neufeld, Khanna, Bramble et al., 1995). Cuban's study of educational change compared a history department and a school of medicine (Cuban, 1997; Cuban, 1999) and showed that educational organizations, whilst they varied in their vision and governance structures, shared many of the same perspectives such as beliefs about roles and professional practice. It was also the case that faculty experiences about their roles in any organization are based on past experiences as learners, then as teachers and then as mentors. I became even more aware of what my own experience as a student at SoM had been like and how this was potentially shaping my reaction to this curriculum reform project. Much of the literature which looked at barriers to implementing reform in medical schools pointed to the arduous work facing those committed to significant curriculum change. Bloom drew attention to the many parallels between medical schools and corporate bureaucracies (Bloom, 1973; Bloom, 1988; Bloom, 1989), describing the medical research profile of the medical school as being of paramount importance compared with the school's educational mission. Bloom also used the metaphor of the giant amoeba, arguing that medical schools tend to "absorb" the effects of innovation and change in ways that seek to preserve their traditional structures and functions. Harden (1998) described the barriers to change in medical education as the direct result of "sclerotic bureaucracy, territorial warfare, raw incompetence and ignorance about the process" (p.189).

Barriers to change in medical education

As I probed the literature further I found many descriptions of significant obstacles to reform in medical schools despite best efforts to implement progressive innovation

(Mennin & Kaufman, 1989; Abrahamson, 1996; Cuban, 1997; Gale & Grant, 1997). Mort and Ross, writing on change in the educational setting in the 1950s, reported that schools typically lagged more than 25 years behind currently espoused "best practice" (Mort & Ross, 1957). Mort (1958) reported that about 15 years were necessary to achieve a 3 percent adoption of any innovation and approximately 50 years was typical for an innovation to become generally incorporated into everyday practice (Mort, 1958). Nearly 40 years later a survey of more than 200 educational institutions found that the average time between adoption of an innovation by one institution compared to adoption of the same innovation by half of the institutions was more than 25 years (Siegfried, Gertz & Anderson, 1995). A similar timescale has been observed in medical education with innovations such as problem-based learning and the objective structured clinical examination (OSCE) (Harden, 1988). Siegfried and colleagues make the suggestion that the reason why the pace of change in education has been significantly slower in colleges and universities than in industry is the lack of "competitive pressures that would force them to stay on the cutting edge" (p. 56).

Large-scale coherent medical education reform has proven a difficult task in many countries. Some have argued that part of the reason for this resistance to change is the pre-eminent position that research has held in the institution's social structure compared with medical education (Bloom, 1988; Bloom, 1989). Cuban (1997) reported a mere 5 percent of medical schools studied had embraced fundamental change – that is, had radically reformed their curricula from the traditional Flexner model to a more integrated curriculum (Cuban, 1997). The Association of American Medical Colleges (1984) identified five specific barriers to change: faculty members' inertia; lack of leadership; lack of oversight of the educational program; limited resources; and lack of evidence that implementing the change would result in the necessary improvements. In 1994, in a comparative case study of six selected medical schools in the US, specific factors were identified that impact upon innovation in medical education. The findings suggest that the culture of each medical school influences critical elements such as educational philosophy, leadership and resources and shapes the type of change that results (Cohen, Dannefer, Seidel et al., 1994):

> Together these forces influence substantially the fate of educational innovations. The institutional culture influences critical elements such as educational philosophy, leadership and resources provided in support of innovation. Equally important, the culture shapes the level and type of change a school considers and implements. The findings also suggest that the availability of resources and the creative impetus present in schools giving priority to research can benefit the educational goals and facilitate educational change. (p. 350)

Most of the barriers which the literature identifies relate to the ways in which medical schools are governed and funded and how these can potentially prevent improved coordination of the undergraduate medical education process. Marsten and Jones (1992) described the organizational barriers as follows: "A division of efforts (departmental autonomy) becomes a barrier to an educational effort like the organ-systems curriculum, which is specifically intended to integrate rather than focus learning on reductionistic scientific thinking." (p. 22).

I was aware of the efforts that had been made at SoM before I arrived, to rearrange the governance structures and facilitate greater integration, and I felt this augured well for the success of the project. I was also aware that this had been a personal vision of the Dean's. In supporting the need to significantly reform the curriculum in his medical school and the need to establish a full-time post in support of these reforms I felt the Dean had demonstrated his commitment to the medical education mission at SoM and shown strong leadership. Calls for a new type of leadership and governance to support medical education reform began in the 1950s (Deitrick & Berson, 1953) when it was recognized that : "The expanded activities of the modern medical school call for a new type of leadership and a new type of organization" (p. 138). Key leadership styles to support reform in medical education formed the basis of many of the papers I read drawing on the work of Peter Drucker and Warren Bennis (Bennis, 1992; Drucker, 1994; Drucker, 1995; Bennis & Thomas, 2004). Much of this writing focused on the Dean's support for the educational mission of the medical school and his/her leadership qualities in managing a centrally coordinated curriculum committee (Hendricson, Payer, Rogers et al., 1993; Reynolds, Adler, Kanter et al., 1995; Daugherty, 1998; Kaufman, 1998).

Leadership and governance in medical education change

Understanding of the various leadership and governance styles necessary to support and sustain curriculum reform in the medical education setting was an important part of my research. I looked to the many leadership theories which clustered into several categories: Behavioural theories (what the leader actually does, e.g. autocratic versus participative) (Blake & Mouton, 1985); Contingency theories (the nature of the task and the environment in which the leader operates determine the type of leadership traits likely to be most effective) (Fiedler, 1967; Vroom & Yetton, 1973); Cognitive theories (leadership as a social attribution, i.e. members of an organization attribute leadership qualities to an individual as a way of defining the organization and the task it has to do) (Sergiovanni & Corbally, 1984; Sims & Gioia, 1986; Fiedler & Garcia, 1987); and Trait theories (the personal characteristics of the leader such as alertness, originality, personal integrity and self-confidence) (Argyris, 1953). Although the trait theories on leadership have failed to discover an effective mix and style of leadership for *all* given situations, there is some evidence that effective leaders are indeed different from other people. Kirkpatrick and Locke's review of the literature suggests that drive, motivation, ambition, honesty, integrity and self-confidence are key leadership traits (Kirkpatrick & Locke, 1991). Bennis and Thomas' research suggests that one of the most reliable indicators and predictors of true leadership is the ability to learn from negative experiences (Bennis & Thomas, 2004). They describe an extraordinary leader as someone who can overcome challenges and difficulties "a kind of phoenix rising from the ashes of adversity stronger and more committed than ever" (p.39). In interviewing over 40 leaders in the business and the public sector they discovered that all had endured "intense, often traumatic, experiences that transformed them and became the source of their distinctive leadership abilities" (p.39). Bennis and Thomas referred to these shaping experiences as "crucibles" after the vessels medieval alchemists used to turn base metals into gold:

> For the interviewees, their crucibles were the points at which they were forced to question who they were and what was important to them. These experiences made them stronger and more confident and changed their sense of purpose in some fundamental way. (p. 39)

In summarizing the essential skills of great leaders, these authors first rated the ability to engage others in shared meaning, the second is a distinctive and compelling voice, the third is a sense of integrity and the fourth is what they refer to as "adaptive capacity", defined as "applied creativity-an almost magical ability to transcend adversity, with all its attendant stresses, and to emerge stronger than before" (p.42).

Extending Bloom's analogy between the medical school and corporate bureaucracy several authors argue that the leadership styles and governance structures which lead to success in the medical education setting are similar to those found in any business circles (Bennis, 1992; Davis & White, 2002). Kaufman argues that "natural leaders within any institution lead by their stature, their charisma, and their accomplishments" (p. 511) and that this is as much the case in medical schools as in any other organizational setting (Kaufman, 1998).

How individuals are led and what governance structures are in place to support change play an important role in introducing change in the educational setting. In two separate studies of over 100 medical schools in the US, Puerto Rico and Canada, it has been shown that the leader in educational change was usually the Dean (Hendricson, Payer, Rogers et al., 1993). Bland and colleagues studied seven projects engaged in changing the health profession's school's curricula and tracked 16 behaviours previously shown to be associated with leaders' effectiveness, placing these into four categories : (1) organizational power (e.g. uses authority; provides rewards or allocates resources) , (2) prestige/coalition power (e.g. empowers others through building coalitions) , (Reynolds, Adler, Kanter et al.), (3) assertive/participative governance (e.g. actively seeks input from others) and (4) cultural/value influence (e.g. articulates the stories or symbols that represent the underlying meaning or purpose of the organization). They found that both the successful and less successful leaders used organizational power behaviors at about the same frequency; however the successful leaders more frequently used participative and cultural /value influencing behaviours than did less successful leaders (Bland, Starnaman, Hembroff et al., 1999). They found overall that participative leadership behaviors were more likely to be correlated with successful achievement of desired curriculum reforms (Bland, Starnaman, Hembroff et al., 1999; Bland, Starnaman, Harris et al., 2000).

The literature also acknowledges the different styles required for different occasions. For instance, leading a medical school through a period of significant curriculum reform requires a different type of leadership than that required when the school it is undergoing a more stable time in its history. Daugherty (Daugherty, 1998) concludes "a nation at peace and a nation under threat require different types of leaders-as do medical schools" (p. 649). Daugherty also points out that few academic leaders in medicine actually plan for or seek training in leadership. And yet leadership skills and the capacity to collaborate are prerequisites for the modern-day medical school Dean:

> Most medical school deans were once medical students, and were selected and trained to be assertive, independent physicians, not to collaborate. For faculty, the medical school environment traditionally values individual autonomy and rewards individual achievement, not behavior that supports a larger community interest... To operate in the new collaborative culture, today's successful dean must meld persuasion with educational statesmanship, always informed by a vision of how the school can prosper and serve. (p. 649)

The literature also recognizes that the Dean alone, however, will not be able to manage the day-to-day operational matters that will lead to curriculum change. He or she will need a faculty member with "intricate knowledge of how the medical school works, is well respected, and has outstanding communication skills" (Davis & White, 2002, p. 925). In most medical schools this position is filled by the Associate Dean of Teaching and Learning or the Director of Medical Education. Such individuals lead the curriculum reform efforts through chairing the various committees charged with developing the new curriculum. It was such a post that I was expected to fill for the first time in SoM. According to Davis and White (2002) this individual must be well supported financially by the Dean and "like the Dean, must be chosen based on his/her ability to perform this particular task: curriculum change" (p. 925). Recognizing that in most medical schools such a person is usually appointed as an Associate Dean and therefore subordinate to the Dean the relevant operational authority issues needing to be addressed are described by Davis and White (2002) as follows:

> Since the departmental chairs will not accord an associate dean the same power they ascribe the dean... Communication between the dean and the associate dean is essential. It is vitally important for the dean to share

> his/her vision for the medical school with the associate dean, and for both to be able to share with the faculty a carefully crafted and thoughtful vision for the future. The associate dean must have the unqualified support and confidence of the dean. (p. 926)

I felt confident that I could fill this role and that in so doing I had the Dean's full support. It seemed to me we shared the same vision for a better integrated and more vibrant curriculum and although I had not participated in the decision to go to a 5-year curriculum I saw in this decision an opportunity for radical rather than incremental reform. Given that it was my understanding that attempts at incremental reform of the curriculum in the past had not been sustained the decision to reduce the duration of the program necessitating a complete overhaul of the entire program, seemed to me an appropriate course of action.

Shortly after commencing in my new role I took the opportunity to undergo a Personality Style Inventory (Myers Briggs) (Myers, Kirby & Myers, 1998) so that I might better understand the shape of my preferences and take these into account when responding to others. This was an important step I felt towards maintaining a critical focus on my own leadership style, which had been shaped up until then by experience in the military and health executive roles but never in the higher education setting. This reflection I felt was important if the team-based work I would be engaged in was to be successful. I also re-examined the literature examining group behaviour and decision making in groups, including group development, performance and effectiveness for I was conscious that most of the work that would be achieved as part of this project of reform would be driven by, in the first instance, dedicated teams (Tuckman, 1965; Posner-Weber, 1987; Cline, 1990; Robbins, 1994; Ivancevich, Matteson & Olekalns, 1997)

Implementing Successful Medical Education Change

Apart from the literature on barriers to change, I found a significant body identifying factors associated with successful implementation of change in the medical education setting. Bland et al (2000) systematically searched the literature on the educational curricular change process in medical schools and identified a consistent set of characteristics which were associated with successful curricular change. These included:

the organization's mission and goals; history of change in the organization; politics (internal networking, resource allocation, relationship with the external environment); organizational structure; need for change; scope and complexity of the innovation; cooperative climate and leadership (Bland, Starnaman, Harris et al., 2000). Furthermore, another report by Bland et al (2000) rejected the commonly held fear that to be successful at curriculum reform there need be deleterious effects on other important outcomes such as research output.

Prideaux (2004) identifies two main approaches to educational (including medical educational) change: centralized or "top-down" and decentralized or "bottom-up". The latter approach claims better ownership and commitment to the change process (Grant & Gale, 1989; Smyth, 1991; Fullan, 1992; Fullan & Hargreaves, 1992; Fullan, 1993; Prideaux, 1999; Prideaux, 2005). Prideaux (2004) recommends the approach used be "sensitive to the nature of the change itself, the culture in which it is to be implemented and the external environment rather than building upon pre-conceived notions" (Vol 8; No.3)

Some of the newer medical schools have put specific governance structures in place specifically designed to support their curriculum reforms, for example Maastricht University (Netherlands) and McMaster University (Hamilton Ontario, Canada) (Bouhuijs, 1993; Neufeld, Khanna, Bramble et al., 1995). Some of these initiatives have been designed to overcome the recognized barriers that often face curriculum committees such as lack of administrative support and "clout" to implement new ideas. A typical curricular governance structure of a medical school in the 1960s, for instance, was a curriculum committee composed of appointed or elected members representing the various school departments. Typically, there was no systematic evaluation of the course and according to Davis and White (2002) "most of the discussion about medical education was opinion-based" (p. 919). Some authors argue such departmental-based governance serves only to reinforce departmental identity (Reynolds, Adler, Kanter et al., 1995), and "generate resistance to cross disciplinary approaches." (p. 672). The newer schools have moved away from departmental-based governance to centralized governance, where the students' educational experience is organized around *what is*

taught not according to departmental structures and where there is a greater focus on continuous curriculum evaluation and renewal (Davis & White, 2002).

When I commenced the new role I was enthusiastic about the opportunity this represented. I would play a significant role in a potentially landmark reform project at the medical school where I trained. I had a vision in mind for the new curriculum which was informed by the literature and aligned with the recommendations of the accrediting body and I was excited about the prospect of implementing and adapting some of the more modern approaches to medical education.

I was pleased by the School's decision to establish a small Medical Education Unit, which I was to direct and felt this office would coordinate the much needed staff development which I was certain was a fundamental part of the curriculum reform strategy. I was also pleased to have been offered a place on the School's executive committee which would allow me to participate in the key decision making activities of the School. My office being proximate to the Dean's would facilitate effective communication between us and the location of the Medical Education Unit on the executive floor of the medical school demonstrated top level support for the enterprise. All of this was again aligned with the medical education literature.

I was conscious however of the finite and limited resource base upon which these plans for reform were based. The four academics and part-time project officer whom the Dean had identified to work on developing the new curriculum were all heavily committed to teaching and had not yet formed a cohesive group. I was mindful that this team represented the full extent of the resources allocated to this project and conscious that this group's performance was critical to the success of the entire enterprise.

As I began to circulate and meet with staff across the campus I encountered a much greater degree of resistance to change and lack of understanding of the need for curriculum reform than I had expected. The literature on change in education and the

medical education context specifically warned of the many barriers to implementing reform in these settings. Most of the barriers which the literature identified related to the ways in which medical schools are governed and funded and how these can potentially prevent improved coordination and integration of the curriculum. In this regard, I was aware of the efforts that had been made at SoM before I arrived to rearrange the governance structures to facilitate greater integration and I felt this augured well for the success of the project.

I was also aware that this curriculum reform project had been a personal vision of the Dean's since he took up his office as Head of the School five years previously. In supporting the need to significantly reform the curriculum in his medical school and the need to establish a full-time post in support of these reforms I felt the Dean had demonstrated his commitment to the medical education mission at SoM and shown strong leadership. His support and vision also augured well for the project. Nonetheless I was not convinced that a "bottom-up" approach to change was occurring at SoM and I felt certain, based on the literature, that this would compromise ownership and commitment to the change process. Starting out I felt the need to be attentive to the concerns of others in implementing reform and for the need to continually reflect on my own leadership.

Individual medical educator experience of change – a gap in the literature

Concentrating on specific cases rather than broad generalizations, I searched the literature for recent examples that afforded insight through interpretation of individual medical educator experience of curriculum reform. Echoing the work of Hall and Hord's using the *Concerns-based Adoption Model* (Hall & Hord, 1987) Chauvin (2002) points out: "A key to successful individual change within the educational organizations is the accurate assessment of individuals' concerns or focus of attention and the careful and appropriate matching of intervention strategies to identified concerns" (p. 998).

The qualitative reflections of the experiences of twelve "seasoned" medical educators from eight US based medical schools who worked to reform their schools' medical curricula as part of *The Robert Wood Johnson Foundation's* "Preparing Physicians for

the Future: A Program in Medical Education" was perceptive (Krackov & Mennin, 1998). Their description included individual reflections on approaches to addressing reform in aspects such as including health promotion/disease prevention and ambulatory care in the curriculum. They included in their report, brief vignettes capturing individual lessons learned by the participants:

> We chose to tell our story of change in a manner that would offer meaning and insight to others... It is not intended to be an exhaustive compilation, and it does not contain quantitative data or *p* values. It presents a qualitative reflection on curriculum change and provides a perspective on what did and what did not work. The story is told by experienced medical educators/participants observers using words of the participants. (p. 1)

However, most of the studies I encountered (including this work) focused predominantly on the *outcomes* of change in medical schools (Bloom, 1973; Mennin & Kaufman, 1989; Cuban, 1990; Cohen, Dannefer, Seidel et al., 1994; Mennin & Krackov, 1998; Schwartz, Loten & Miller, 1999; Bernier, Adler, Kanter et al., 2000; Bland, Starnaman, Harris et al., 2000).

Little research focused on the process of change in medical education and none of the research examined the impact change has on the lives of professional academics in the medical school setting. And yet to successfully implement change, we must better understand the experience of change by medical teachers.

The need to better understand individuals and their roles in organizations has long been accepted (Getzels & Guba, 1957). Most managers know that individuals do not come to organizations as "blank slates", but instead bring with them sets of personal beliefs, norms, values and prior experiences. Roles in organizations are filled by:

> Real, flesh-and-blood persons, and no two persons are exactly alike. An individual stamps the particular role he fills with the unique style of his own characteristic pattern of expressive behaviour... To understand the observed behaviour... It is not enough to know only the nature of the roles and of the expectations... but we must know the nature of the individuals inhabiting the roles. (p. 427)

Given the complexity of curriculum reform in medical education, it seemed to me a significant gap in the literature. What was missing, I felt, was a means to better understand how curriculum and governance change is experienced in medical schools – in particular how senior medical educators, charged with implementing curriculum reform in their own medical school, experience the change process.

Listening to individual stories about change and telling my own personal story became for me the key focus of this study. I would turn to my own personal experience of leading the curriculum reform project and the experience of those who worked alongside me in this endeavour to examine and explore the individual experience of curriculum change in a medical school.

Selecting an Appropriate Methodology

Ethnography

One methodological approach I considered at the start, which I felt might be commensurate with the aims of the study, was ethnography. The purpose of ethnography has been defined (Hatch, 2002) as capturing culture or parts thereof "from the point of view of cultural insiders" (p. 21). My role in the medical school, as Director of the Medical Education Unit, and therefore "cultural insider", permitted an ideal observation point to examine details of the curriculum planning and reform process over a three year period. In the past, ethnography generally involved field research in unusual and more "interesting" locations. In recent times however, ethnography has increasingly focused on the study of local cultures and settings, i.e. research "at home" (Jackson, 1986). It was the everyday ordinary issues facing a group of medical academics who became involved in curriculum change in a medical school that held particular appeal for me.

The practice of ethnography typically involves lengthy immersion in the everyday life of a particular setting (Pope, 2005) and "this is accomplished by becoming part of that everyday life, principally by observing interactions and behaviour, but also by talking to the members of the social world being studied and looking at the documents or artifacts

they produce" (p. 1180). The particular setting of medicine and medical education provides a unique vantage point (Atkinson & Pugsley, 2005), for the discipline is "permeated by the activities of reading and writing" providing an ideal opportunity for close examination of a particular medical education organization:

> The ethnography of medical education may, therefore, also incorporate the collection and analysis of documentary sources, such as curricular materials, minutes of meetings, newsletters and so on...they will be inspected for their taken-for-granted assumptions, their rhetoric, their intended effects upon readers and audiences, and the uses to which they are put within the organization. (p. 231)

The three year planning phase of curriculum reform at the SoM was also likely to be "permeated" by a proliferation of documentation pertaining to the development of the new program, from which this study might draw particular insights.

Ethnography's other appeal is that has been used in the medical education setting for over 50 years (Merton, Reader & Kendall, 1957; Becker, Geer., Hughes et al., 1961; Fredericks & Munday,1976; Haas & Shaffir, 1987). The classic 1960s study *Boys in White.*(Becker, Geer, Hughes et al., 1961) described the study demands placed on medical students and how students worked out ways to make these demands more manageable. Another account of life in a medical school was that of Bloom, whose account of three years of observation, interviews and questionnaire surveys at the State University of New York Downstate Medical Centre focused on the relationship that existed between faculty and students and the attitudes of faculty and students towards their medical school (Bloom, 1973). What he encountered was a divided institution in which the needs of students were subverted to those of faculty.

In the UK, Atkinson investigated bedside teaching of medical students in the Edinburgh Medical School, which for many years remained the only published ethnographic account of medical education in the UK (Atkinson, 1981). In his original monograph, Atkinson makes the distinction between his account of medical student education and that of Becker's, claiming that his monograph attempts to capture more fully the students' experience of clinical instruction and "move the gaze" accordingly to the students' understanding of medical education. More recently, Sinclair wrote of the

rituals of medical student life, based on his study in a London Medical School (Sinclair, 1997). Sinclair's purpose in writing this account was to "fill a large ethnographic gap" by providing a full account of the training of doctors. Sinclair points out that it is only through such an account "that the way the training collectively transforms individuals can be fully understood" (p. 4).

This study of curriculum reform at SoM planned to move "the gaze" away from the student's experience of medical education to that of faculty – particular those charged with the responsibility of effecting significant change in the medical curriculum. Atkinson and Pugsley (2005) call attention to ethnography and the role it can play in the context of training doctors, particularly given the many changes occurring currently in the medical education setting:

> Given the enormous policy changes that have impacted on medical education, there is a need for close and prolonged ethnographic engagement with medical students, junior doctors and other health care professionals in order to explore and change the many assumptions that exist in these settings and which are taken for granted. (p. 229)

Pursuing a purely ethnographic approach and relying totally on *my own* powers of observation, however, posed a particular dilemma for me. I ran the risk, as Seidman (1985) points out, of placing "the burden of constructing meaning" on myself alone (p. 14). The purpose of this study, however, was to better understand medical education reform through the eyes of medical faculty (including myself), and how they [we] understand and make meaning of the roles of a medical academic in times of change. I wanted *all* of the voices of this particularly literate medical culture to be heard and did not want to speak for them. Writing about capturing the stories and experience of other literate organizations, especially those with a "managerial tilt", Czarniawska (1997) asks the relevant question "Do we silence them by speaking for them? Do we represent them more fully than anybody else?" (p. 196) I likewise did not want to "silence" my colleagues in the medical school by speaking for them or diminish their perspective in any way by interpreting on their behalf.

I therefore turned my focus to another methodology – narrative inquiry.

Narrative Inquiry

Clandinin and Rosiek (2007) describe the purpose of narrative inquiry as capturing the way people go about "making sense of their experience...and contributing to that ongoing sense making" (p.45). They describe narrative inquiry as a "relational form of inquiry", in which "multiple contexts beyond the researcher's control – such as spatial contexts, cultural contexts, social contexts, institutional contexts, place contexts, and people contexts – are always present".(p.45). It was the sense making aspect of curriculum change that I felt compelled to collate for myself and with my colleagues. Through the process of narrating my own story, I sought to acquire a greater appreciation of the "other possibilities, interpretations, and ways of explaining things" (Clandinin & Rosiek, p.46) and a fuller understanding of my own privileged place in this landmark project.

Polkinghorne (1988) describes the use of narrative as the human attempt "to progress to a solution, clarification or unravelling of an incomplete situation" (p. 7) and the place of narrative in our daily lives as follows:

> Our lives are ceaselessly intertwined with narrative, with the stories that we tell and hear told, with the stories that we dream or imagine or would like to tell. All these stories are reworked in that story of our own lives which we narrate to ourselves in an episodic, sometimes semiconscious, virtually uninterrupted monologue. (p. 160)

In this same manner, I planned to narrate stories of leading curriculum change in a medical school and to use these stories to help me think about and better understand my own actions and reactions to what was happening around me. Chase (2005) describes narrative as a distinct form of discourse, defining it as "retrospective meaning making- the shaping or ordering of past experience" (p. 656).

The defining characteristics of narrative described by Greenhalgh and her colleagues (Greenhalgh, Russell & Swinglehurst, 2005) were all elements that this study, which would examine curriculum reform process over time, would satisfy:

> chronology (unfolding over time); emplotment (the literary juxtaposing of actions and events in an implicitly causal sequence); trouble (that is, harm or the risk of harm); and embeddedness (the personal story nests within a particular social, historical and organisational context). (p. 443)

Descriptive narrative research has an established place in describing change in organizations and has been used by organizational analysts to help understand how others make sense of events in their lives and within organizations (Boje, 1991; Czarniawska, 1997; Czarniawska, 2002; Czarniawska, 2007). As far back as the beginning of the 20th century Thomas and Znaniecki, authors of the landmark life history *The Polish Peasant,* pointed to the value of narrative in the context of organizations (Thomas and Znaniecki, 1927):

> A social institution can be fully understood only if we do not limit ourselves to the abstract study of its formal organization, but analyze the way in which it appears in the personal experience of various members of the group and follow the influence which it has upon their lives. (p. 1833)

Polkinghorne (1988) describes the use of narrative research by organizational analysts as seeking to uncover the "values" and "assumptions" of an organization:

> For example... letters and manuals can uncover, together with interviews, the various understandings of the organization's story...Do the members of the organization hold to a single story and acknowledge the roles they are performing as part of a coherent organizational narrative? (p. 162)

In a similar way, I was keen to uncover whether in this medical school undergoing change there was just one story about curriculum change. Were there many? And were there unifying themes that spanned all stories?

Boje (2007) describes storytelling in organizations as the "preferred sense-making currency of human relationships". Boje also suggests that an organization's stories are recounted by its members and continually compared to unfolding events' story lines in order to:

> keep the organization from repeating historically bad choices and to invite the repetition of past successes. In a turbulent environment, the organization halls and offices pulsate with a story life of the here and now that is richer and more vibrant than the firm's environments. (p. 106)

Stories within an organization form part of what Boje (2007) refers to as "an organization-wide information-processing network" (p.106). As I met with academics across SoM many had taught there for a significant time, in some cases close to 20 years. They had stories to tell about curriculum change long before I arrived, forming what
Boje describes as the "institutional memory system of the organization" (p.106).
I felt certain this three year project would add and extend to that story-line and that through my own involvement I too would have stories to tell and re-tell, shaped by my own personal experience of this reform.

In the education organization context, the work of Clandinin and Connelly (1996; 1998) and Craig (2001) recognizes the place that school teachers' "narrative identities" play in understanding their experiences of and their roles in curriculum reform. Craig (2001) refers to teachers' "lived experience of school reform" (p. 304) as an important means to answering questions about teachers' understandings and implementations of reform.

I discovered that narrative research, like ethnography, also had an already established place in the health care setting. Narrative inquiry has been used to describe the illness experience and the patient-doctor relationship (Balint, 1955; Kleinman, 1988; Hunter, 1991; Hunter, 1996; Hurwitz & Greenhalgh, 1998; Hurwitz, Skultans & Greenhalgh, 2004; Ziebland & McPherson, 2006). Narrative is a critical part of health care. Muller (1999) argues that: "Nowhere is this more apparent than in the world of sickness and clinical practice, where the currency of communication is often the story" (p. 221). Rita Charon first coined the term *narrative medicine* (Charon, 2001) to describe what she saw as a critical component of effective clinical practice: "Physicians are reaching to practice what I have come to call *narrative medicine*—that is, medicine practiced with the narrative competence to recognize, interpret, and be moved to action by the predicaments of others" (p. 83). Charon's own clinical practice informed this understanding:

> After a few years of practice after residency, I realized that what patients paid me to do was to listen very expertly and attentively to extraordinarily complicated

> narratives – told in words, gestures, silences, tracings, images, and physical findings – and to cohere all these stories into something that made at least provisional sense, enough sense, that is, to be acted on. (p. 83)

Narrative has also been used in the health care setting to focus on the stories of medical practitioners and their professional interactions. Kaufman (1993) studied seven elderly physicians and observed the changes occurring in their personal and professional lives over the 20th century. Kleinman reviewed the narrative accounts of practitioners caring for the chronically ill (Kleinman, 1988). Hunter (1991) studied physicians' use of narrative in both the practice of medicine and in medical education.
The important role of patient narratives in medical education is now well established. The new curriculum in Harvard Medical School uses a case study approach where medical cases are stories of real patients (Lyons, 2007). Bleakley (2005), however, is guarded about the manner in which medical education requires medical students to conform to an outmoded standard practice of "case presentations", arguing that such a practice "in transforming the patient's story, may compromise empathy." (p. 539). Bleakley refers to such practice as potentially privileging "convergent and analytical approaches to story over divergent approaches" arguing that in so doing we as medical educators of future doctors may not be encouraging as we ought the capacity for "sensitive listening through story" (p. 539). As an alternative the use of a narrative reflective practice approach was recently described (Clandinin & Cave, 2008) as a means to assist junior doctors develop their professional identities "as technically skilled as well as caring, compassionate and ethical practitioners".

I felt confident that narrative inquiry would provide the most appropriate methodology to focus on the individual experience of change in a medical school and in particular to help illuminate the lived experience of curriculum reform and the sense making as it happens over time by experienced senior medical educators charged with implementing significant curriculum change.

I planned to collect narrative accounts of this particular episode of historic curriculum reform at SoM in the form of interviews, observations and collected correspondence and text. I proposed to illuminate meaning from these accounts including my own and, as

Ollerenshaw and Creswell (2002) describe, "restory" (Ollerenshaw & Creswell, 2002) all the participants' accounts, including my own, and place them within the context of a chronological sequence and spatial setting in a similar way to Clandinin and Connelly's three dimensional space approach (Clandinin & Connelly, 2000).

I sought to do this in such a way as to bring to the foreground the particular rather than the general and in so doing value and uphold the elements of individual experience of curriculum reform which are unique, idiosyncratic and distinctive. Turning in a different direction from the positivist traditions of my earlier medical training, I sought to look beyond mere attempts to generalize or extrapolate meaning from my own story and those of others. I understood the inevitable "tradeoff" between "proximity" and "certainty" which I would now need to make (Clandinin & Rosiek, 2007) as a narrative inquirer:

> What narrative inquirers gain in the proximity to ordinary lives experience and the scope of their considerations, they, at times, sacrifice in certainty. Narrative inquirers work with an attitude of knowing that other possibilities, interpretations, and ways of explaining things are possible. This sense of uncertainty or tentativeness is one of the most visible and remarked on in the differences between narrative and post-positivist inquirers. (p. 46)

I had already developed at the outset of this project an impression that there were already multiple ways of knowing and understanding curriculum reform, given the stories I had begun to listen to.

Incorporated Personal Narrative and Researcher Positioning

The unique place I occupied in this project as Director of a newly formed Medical Education Unit and leader of the development of the new curriculum meant I was well positioned to provide an "insider" perspective. Hayano (1979) is credited as having originally coined the term "auto-ethnography" (p. 99) when he referred to studies by anthropologists studying their "own people" with the researcher being a full insider either by acquiring intimate familiarity with the group or achieving full membership in the group being studied (p.100). The advantage of writing as an insider is the potential to

share "unique cultural or subcultural experiences and specialized knowledge... and not matter-of-factly submerge them under conventional anthropological paradigms" (p. 103). In defining a place for this genre of writing in the 1970s, Hayano pointed not only to the potential for "voices from within" (p. 103) to be heard, but also acknowledged the role of auto-ethnography in informing programs of change and development.

Behar (1996) speaks of auto-ethnography as writing "vulnerably". She also highlights an important and unique risk associated with this genre, namely the repercussions of *failing* to capture the reader's interest:

> It is far from easy to think up interesting ways to locate oneself in one's own text... The worst that can happen in an invulnerable text is that it will be boring. But when an author has made herself or himself vulnerable, the stakes are higher: a boring self-revelation, one that fails to move the reader, is more than embarrassing; it is humiliating. (p.13)

In this study, my aim was to locate myself in the text in order to achieve the specific outcome of taking the reader "somewhere we wouldn't otherwise get to" (Behar, 1996, p. 14).

By placing myself explicitly in the text I was aware that I was disrupting the traditional positivist research relationship. The positivist notion has typically held that there is a need to maintain a distance between one's personal perspectives and the research and that any interaction between researcher and research participants (or between researchers and narrators in the case of storytelling approaches) be seen as a source of bias. The inclusion of my self narrative has exposed many aspects of my own personal journey over the three years of the project. Chase (2005) acknowledges such approaches as potentially opening the researcher to criticism that they are "self-indulgent" (p. 666); however, the alternative position suggests that opening up the researcher in this way seeks to demystify what has been described as the "disengaged" and "omniscient" author (Tierney & Dilley 2002 p. 389). Richardson claims that even if we were to consider "disengaged" authorship as possible in fact all writing is "tainted" by human hands (Richardson 2001) and that "people who write are always writing about their lives, even when they disguise this through the omniscient voice of science or

scholarship" (p. 34). In seeking then to "turn the analytic lens" (Chase 2005, p. 660) on myself and portray my lived experience of curriculum reform my aim is to "show" (rather than to "tell" about) this experience of change from my personal viewpoint (Denzin, 2003, p. 203).

The Aims and Objectives of the Study

This particular study sits then in a watershed, intersected by the theory of organizational change, narrative and curriculum reform. It is located within the constructivist paradigm – the assumption being that absolute realities are unknowable and that researcher and respondent construct together the subjective reality. The products of the constructivist paradigm allow the reader to "place themselves in the shoes of the participants" (Hatch, 2002, p.16). Unlike the positivist tradition this study is less concerned with forming generalizations, hypothesis testing or making predictions. Instead, it is interested, as Cohen (1991) describes, with "creating a window onto a piece of ongoing, idiosyncratic, real-life experience" (p. 6). Denzin and Lincoln (1994) describe the criteria for judging the quality of such endeavour as follows: "Terms such as credibility, transferability, dependability, and confirmability, replace the usual positivist criteria of internal and external validity, reliability and objectivity" (p. 14).

The purpose of this research was to capture the myriad lived experiences of curriculum reform amongst medical academics in an Australian medical school. In particular I sought to capture the phase often taken for granted – the planning phase – during which new ideas about curriculum outcomes, delivery and assessment are developed, tested, refined and communicated (Mennin & Kaufman, 1989; Lindberg,1998; Bland, Starnaman, Harris et al., 2000; Christianson, McBride, Vari et al., 2007). The perspectives presented in this study are both my own as coordinator of the curriculum change process during the three years of planning and those of senior academics who worked alongside me on this project. I have also included the perspectives of the current and former Deans of the medical school, who shared with me their perspectives of curriculum reform over the schools 38 year history.

The particular time frame for this study began in late October 2002, when the New Curriculum Working Group (the working group established by the School to develop the new curriculum and which I chaired for three years of the project) and the Medical Education Unit (the unit established to support curriculum reform) were established. The study period concludes in December 2005, when the AMC handed down its accreditation decision and formally endorsed the School's plans to commence the new medical program.

The major premise of this study is that through an understanding of the lived experience of change by medical faculty in a medical school undergoing *significant* curriculum reform, it will be possible to better appreciate the complexity of curriculum reform in a medical school and the diversity of the lived experience of change by senior members of faculty.

The first broad aim of this work is to contribute to an understanding of how senior members of faculty in a medical school, including myself, construct meaning through their particular lived experience of curriculum change. I have targeted participants who were publicly committed to curriculum reform and occupied positions of influence and responsibility as far as the curriculum was concerned. These were individuals whose "achievement both inside and outside the classroom were ongoing and impressive" (Cohen, 1991 p. 5). I contribute my own story of situated lived experience of change and how I personally went about making sense of that experience, in my role as Director of a newly formed Medical Education Unit and Chair of the New Curriculum Working Group. I use self narrative as a reflexive means of contributing to my personal transformative growth as an agent of change in curriculum reform. The study aims to elucidate the depth and breadth of different experience of curriculum change by senior members of faculty charged with the responsibility of introducing significant reform. Through parallel stories difference in *sensemaking* is highlighted as personal and distinctive as well as capable of coexisting and being reconciled with other interpretations. This study also seeks to explore some of the theoretical understandings of change in education and organizations generally and to highlight tensions that exist between theoretical understandings and lived experience of curriculum change.

In summary, the aims of the study are to investigate the lived experience of curriculum change in a medical school over time and to problematize current theoretical understanding of curriculum change; to contribute my own personal story of situated lived experience of leadership of a major curriculum reform project and to examine how reflexive self narrative can lead to transformed self understanding of the role as change agent in a medical school and; to explore how narrative inquiry can provide a new dimension to our understanding of curriculum reform in medical education.

Chapter 3 – Methodology

Introduction

In Chapter 2, I described the theoretical framework for this study. In this chapter I describe how these principles have informed the methodological approach used.
I begin this chapter by discussing narrative methodology and how this methodology improves our understanding of others' experience through the collection and "re-storying" of others' stories of life experience. I describe the approaches I used to collect my story and the stories of others involved in curriculum reform in SoM. This includes a discussion of selection and recruitment of participants, data generation and data interpretation. I conclude the chapter by exploring the challenges I encountered using this methodology.

Narrative Methodology

Since the 1960s the notion of using narrative as a specific research methodology has permeated many disciplines, which is not surprising as stories are "one of the ways that we fill our world with meaning" (Clandinin & Rosiek, 2007, p. 35). The telling and retelling of stories about relevant life events is increasingly gaining legitimacy in educational research (Clandinin & Murphy, 2007; Ollerenshaw & Creswell, 2002; Ollerenshaw & Lyons, 2002) where the narrative approach has helped examine a variety of aspects including teacher identity (Connelly & Clandinin, 1988); teacher professional development (Butt & Raymond, 1989); life stories (Goodson, 1997); teachers' curriculum stories (Clandinin & Connelly, 1996) and the impact of curriculum reform on teachers' lives (Clandinin & Connelly, 1998). Narrative inquiry has also found a place in other disciplines including psychology (Bruner, 1986; Mishler, 1986; Polkinghorne, 1988) and social science (Hatch & Wisniewski, 1995; Richardson, 2001; Tierney, 1998).

The approaches used by the narrative inquirer are very different from the post positivist. The narrative inquirer seeks to remain embedded in the human experience or "within the

stream of human lives" (Clandinin & Rosiek, 2007, p. 44), whereas the post-positivist seeks to define reality from a viewpoint "that stands outside human experience" (p.44). Narrative inquiry, then, is intimately connected to the experience and is "first and foremost a way of thinking about experience" (Connelly & Clandinin, 2006, p. 375). This study seeks to place foremost the experience of curriculum change and aims to do this by remaining intimately interwoven with the lives of those in whom the events are occurring.

It is also important however to acknowledge how the telling of a story also shapes the experience that informed the storytelling. It is not a detached and neutral process, for in telling about events and making them meaningful, we also add meaning. It is both "a description of, and intervention into, human experience" (Clandinin & Rosiek, 2007, p 44). In this description of my own personal encounter with medical curriculum reform and in retelling others' stories of the same events differently experienced, I am not the indifferent and impassive storyteller. I am instead actively shaping my experience of and enlightening myself about reform by living, telling and retelling. Like the potter's wheel turning, the telling of the events has moulded the experience that was.

The process of "restorying" in narrative is likewise an active process. I analyzed the stories looking for the defining characteristics of place, plot, protagonists and predicament and then rewrote the story within a chronological sequence which in this case was the three-year period of the curriculum reform project. Ollerenshaw and Creswell (2002) point out that the narrative researcher's role is "more than [just] description and thematic development" (p.330):

> It involves a complex set of analysis steps based on the central feature of "restorying" a story from the original raw data. The process of restorying includes reading the transcript, analyzing this story to understand the lived experiences and then retelling the story. (p.330)

Using a narrative approach, data are obtainable from any available source of text. This can include interviews, journals oral history, photographs, artefacts, memoirs, speeches, conversations, emails, minutes of meetings and visual records such as video and photographs. In this study I found an abundant source of text in the field, including

curricular materials, minutes of meetings, newsletters, historical records and so on. Semi-structured in-depth interviews, my own reflective journal and personal recording of all correspondence I and the curriculum planning team generated in the three year period added to this to provide a rich source of text data.

As a narrative researcher I saw the data generation process as one of co-constructing meaning together with the participants. I sought to re-story their accounts in a collaborative way. We went over the stories together, I sharing my accounts with them while they shared their interpretation of events with me. We lived together this story of curriculum reform. My own field observations and records of events and storied accounts feature prominently in the data that were collected over time. The data interpretation process, unlike the post-positivist tradition, occurred alongside the data collection. The process of turning "field texts into research texts" (Clandinin & Connelly, 2000, p. 119) required taking the raw field stories told to me by my colleagues and reconstructing them (Kvale, 1996), but being careful to maintain their integrity or "unity of form" (p.184) between the original interviews, my analysis and the final story.

Outline of Procedures Followed

The following table outlines the research design. A detailed description of each step follows.

Methodology summary:

- Ethics permission sought to conduct the study and was granted by the Human Research Ethics (Social Science) Committee University of Southern State.
- Permission sought from the Dean of the Medical School to conduct the study
- Contact was made with all former Deans of this Medical School to seek their participation
- Contact was made with all key members of the New Curriculum Working Group (NCWG) and Statewide Clinical Schools Working Group (SWCSWG)
- Six members of the curriculum working groups were the principal participants of the study
- Five former Deans of the Medical School and the current Dean also agreed to be interviewed
- All participants read study information sheets and completed participant consent sheets ratified by the Ethics committee
- Text data collected over the three year period from end 2002 to end of 2005 included:
    - All NCWG minutes of meetings
    - All curriculum planning documentation
    - All curriculum newsletters
    - All correspondence generated by the new curriculum working groups to internal and external stakeholders (i.e. Medical Council, Medical School advisory boards; Department of Health etc)
    - All feedback sent to NCWG from staff relating to plans for the new curriculum
    - All documentation relating to planning of and delivery of staff development in support of new curriculum including school wide gatherings and Forums
    - All media (medical school/university/public) coverage of new curriculum plans
    - All documentation to and from the accrediting body the Australian Medical Council
    - Archived material available from the State Archives office relating to the history of the medical school and the Schools relationship with accrediting bodies
    - Handwritten notes given to me in support of interview with oldest living Dean of the medical school

Data Collection

- The curriculum working group participants were interviewed twice in semi-structured interviews lasting 1.5 hours. The interviews were audio-taped using a hand held recorder and later transcribed.
- The Deans were interviewed once in a semi-structured interview lasting up to 1.5 hours.
- My reflective journal was maintained between 2002 and 2005 and consisted of brief field notes and impressions.

Data Interpretation

- Data were interpreted using narrative analytical procedures (Polkinghorne 1995)
- Data interpretations were used to construct four chronological chapters to restory the experience of curriculum reform.

Table 1. Research procedure followed.

Selection of Participants

Apart from my own story, I was particularly interested in conveying the perspectives of colleagues who worked alongside me on the reform of the medical school's curriculum. Between October 2002 and December 2005 this work was undertaken by select working groups composed of academics (clinicians and scientists) and project officers. One of these groups was principally responsible for planning the new 5-year curriculum and was called the "New Curriculum Working Group" (NCWG). This working group later became known as the Five-Year Curriculum Working Group[9]. In addition, a number of academics from the three clinical schools (which were located at three sites across the island) formed what later became known as the Statewide Clinical Schools Working Group (SWCSWG) to oversee ongoing curriculum reform of the last two years of the existing 6-year course in preparation for "grafting" onto the new five-year curriculum by 2009. The process of incremental reforms to the existing 6-year program had begun in 2002 with the introduction of "case-based learning"[10]. The proposal was that the last two years (years five and six) of the existing 6-year course would become (with modifications to mode of delivery and assessment) the final two years of the new 5-year curriculum.

From this pool of academics potential participants were invited to participate in this study on the basis of their willingness to talk frankly about their involvement in and lived experience of the curriculum development and reform process. In a manner similar to Cohen's (1991) description of the individuals she selected as part of her study, these were professionals who were directly involved in the day to day activities of the curriculum reform project and whose "candor about the profession and about themselves" (p. 4-5) meant they were prepared to talk freely about their experience of the project and the curriculum reform process generally. All the participants selected had been engaged in the curriculum reform project for most of the three year period under study, i.e. between end of 2002 (when the decision to develop a new 5-year curriculum

[9] The name "New" Curriculum Working Group was felt to potentially cause offence to the existing "old" six-year curriculum by implying that the existing course, despite being fully accredited, was somehow inferior.

[10] A hybrid of problem-based learning.

began) and end of 2005 (when the accrediting body endorsed the new curriculum plans permitting the new program to commence).

In order to provide an historical context for these personal accounts, the perspectives of those engaged in curriculum reform in the School's past history – i.e. in the preceding thirty eight years – were sought through semi-structured interviews with the current and former Deans. All but one of the former living Deans agreed to participate. The current Dean also provided a personal account of his 18 year history with the medical school from his initial appointment as senior lecturer to his taking up his appointment as Dean.

Following full endorsement by the University's Research Ethics (Social Science) Committee[11] letters of invitation to all potential participants were sent out to members of the two curriculum reform teams, i.e. the NCWG and the SWCSWG. The letter of invitation and the information sheet provided to the members of the current team are included as Appendix 1, while the letter of invitation and information sheet provided to all former Deans of SoM are included as Appendix 2.

The consent form, signed copies of which were received from all participants, is included as Appendix 3.

Interviews

Semi-structured Interviews with Colleagues – Philosophical Underpinnings

Some of the most interviewed groups in educational research have been teachers, administrators and policy makers (Tierney & Dilley, 2002): "these persons have traditionally been viewed as being "in the know" " and, as a result, have been regarded as the "respondents of choice"(p. 459). I was likewise keen to explore how colleagues in a medical school – some senior teachers and some both teachers and senior administrators – were making sense of their professional work and lives as I myself was trying to in this time of significant reform. I wanted to know how they were availing of their own frameworks of knowledge and experience to articulate and make sense of this

[11] http://www.research.utas.edu.au/human_ethics/social_science.htmapplication

task we had all become immersed in. When we met to share our stories I was conscious of the need to step out of our usual planning mode into a more relaxed frame of mind. I was also conscious of my own training in interview technique which derived from the medical model (Balint, 1955). Although this had evolved over my career in medicine to include use of more open-ended style of questioning and patient centeredness (Lloyd & Bor, 2004; Neighbour, 1987; Silverman, Kurtz, & Draper, 2005) I was aware of the different context in which these interviews or purposeful conversations were taking place and that I would be talking with colleagues with whom I had a close working relationship to co-create an account of their lives.

I wanted the interviews to reflect a move away from the structured approach to questioning commonly associated with structured interviews. Instead, these interviews were to conform to what Kvale (1996) describes as a guided conversation with a rationale:

> The inter-view is an inter-subjective enterprise...The interviewer does not merely collect statements like gathering small stones on a beach. His or her questions lead up to what aspects of a topic the subject will address, and the interviewer's active listening and following up on the answers co-determines the course of the conversation. (p.183)

Fontana and Frey (2000) encapsulate the "modern" interview in the terms "negotiated text" (p. 663), describing the place of interviewers in the process as follows:

> There is a growing realization that interviewers are not the mythical, neutral tools envisioned by survey research. Interviewers are increasingly seen as active participants in interactions with respondents, and interviews are seen as negotiated accomplishments of both interviewers and respondents that are shaped by the contexts and the situations in which they take place. (p. 663)

Hatch (2002) makes a distinction between informal and formal interviews, with the latter being further categorized according to the degree of structure (p. 92). These interviews were formal insofar that I came to the interviews with guiding questions (see Appendix 4) but semi-structured in that I was open to following the leads that my colleagues generated and probed areas that arose during the course of our conversations (Hatch, 2002).

When we came together to share stories with each other, I had to make the conceptual shift away, as Chase (2005) describes, from thinking of my colleagues as interviewees with answers to questions and "towards the idea that interviewees are narrators with stories to tell and voices of their own" (p. 660). Although our coming together was principally to capture their perspectives, if what they told me resonated with my own experience, then I told them so. I helped them and they helped me to reflect on our individually lived experience of the "same" curriculum change. During each of the interviews I listened carefully for "opportunities to take the conversation to a deeper level of meaning" (Hatch 2002, p. 111) by inviting reflection and seeking examples. As a medical practitioner, with 15 years of clinical experience, I was familiar with the approach referred to as "active listening" (Robertson, 2005) – a structured form of listening and responding that focuses the mind on what is being said. I occasionally needed to pause the conversation to seek clarification about what was meant by a certain phrase. However, my familiarity with medical education and the context of this particular medical school and the issues faced attempting to introduce change, meant I already had an "ear" for the "linguistic style" that was used. I felt I had a sense for the stories being told and so was able to assist my colleagues in the "unfolding of their narratives" (Kvale, 1996, p. 147).

This familiarity with the context as well as the sharing of some of my own perspectives in these semi-structured interviews reduced the likelihood, I felt, for my colleagues relating accounts that were "primarily designed to present the self in socially valued images" (Polkinghorne, 1988, p. 164). What emerged were honest, frank and unsanitized personal accounts of the lived experience of curriculum reform in a medical school.

The Interviews – General Comments

In total,12 interviews were conducted with members of staff at the medical school including five former Deans. All of the interviews were conducted in a convenient quiet location that was acceptable to the participants. The venue for the interviews ranged from participants' professional rooms, to university offices and homes. In accordance with convention the interviews were framed at the start by providing the participants with the context for the interview i.e. the purpose of the interview, the use of the tape

recorder and the fate of the transcripts (Kvale, 1996). I began each interview by stressing that this was *their* story, that there were no "right" or "wrong" answers and that they could review the transcript after the meeting to add or retract anything they said at any time. Importantly I stressed to each that what I really wanted to hear was their personal account of *what it was like* being involved in curriculum reform or, in the case of the former Deans, what it was like establishing the curriculum for the very first time. I explained that I was particularly interested to hear about events that represented particular highlights in their working lives related to curriculum reform. Tierney (1998) refers to such events as "peak" or "nadir" experiences which tell us something about the ideology that drives their lives and the images they have of both their own lives and that of others.

The taping of the interviews did not appear to interfere with the process. Most of the participants found this a familiar activity and were accustomed to recording medical school meetings for the purpose of minute-taking. The tape-recording meant I could pay close attention to what was being said and maintain eye contact with the participants which encouraged a conversational style between us:

> Contrary to conventional wisdom, the tape recorder can work to make the participant more comfortable rather than less comfortable with the interviewing process. The tape recorder allows the interviewer to concentrate on what the participant is saying and on the interviewing process rather than on capturing in writing what is said. (Seidman, 1985, p.21)

Although transcripts were returned to the participants, none chose to alter the transcripts in any way. Two participants commented on the peculiarity of seeing their own words in the form of written text. In some instances the transcript of the first interview was used by some colleagues to emphasize or clarify certain aspects in the second interview. None of the former Deans accepted the invitation to review the transcripts but all expressed gratitude at having been given the opportunity to share their experience.

Interviews ranged in duration from between one to one and a half hours. Seidman (1998) argues in favour of a 90-minute interview. However, I was also aware of issues raised by Hatch (2002), such as "how much the informant is willing to share, how tired or fatigued you both become, and how well the guiding questions are being addressed" (p. 111), and

allowed these to inform the duration of the interviews. On one occasion the interview had to be terminated earlier than anticipated as one of the participants was called to theatre, and we simply rescheduled the meeting. The single informal interview with the former Deans also lasted up to an hour and a half.

Semi-structured Interviews with Current Curriculum Reform Team

The interviews with the members of the NCWG and SWCSWG occurred during the critical planning phase of the new curriculum and not the implementation phase. I was interested in the personal accounts of curriculum planning, during the period of uncertainty when the fate of the new curriculum remained unknown. The planned visit by the Australian Medical Council (AMC) to the School in May 2005 provided a natural break in the planning phase so the interviews were scheduled to occur before and after this visit, but in both cases *prior* to the final accreditation visit result being known.

I initially decided on an interview schedule based on Seidman's (1998) model of three interviews with the first interview establishing "the context of the participants' experience", the second interview reconstructing "the details of their experience" and the third to encourage reflection on "the meaning of their experience" (Seidman, 1998). As the interviews unfolded I recognized that this somewhat artificial separation was impractical for my purpose. My already close working relationship with the participants obviated in some cases the need for the interviews to dwell too long on either participant context and so we naturally moved through this description to the details of the curriculum reform experience in the first interview. Likewise where I was already familiar with the details of the experience I encouraged the discussion to focus on ascribed meaning with the second interview picking up points from the first interview for emphasis or clarification.

The first interview began by inviting participants to tell me something about how they came to be involved in curriculum development and to describe any particular life events which helped develop or affirm an interest in medical education. Hatch (2002) describes these questions as "descriptive": "descriptive questions are designed to get informants talking about the particulars of a social scene with which they are familiar" (p. 104). I

used open ended questions which sought to establish the participants' specific role in medical curriculum development past and present. Example questions included:

- *"Can you tell me about how you came to be involved in medical education and curriculum development?"*
- *"Were you always interested in this sort of work?"*
- *"Were there any particular events in your life which helped develop or affirm this interest?"*

All of the participants were forthcoming in their responses requiring little probing questions on my part. Having said I was already familiar with the participants it surprised me how little in fact I understood of the context and rationale for their decision to join the curriculum reform project, despite our having met fortnightly at our curriculum planning meetings for in some cases two and a half years.

The second interviews were scheduled for six months later, allowing sufficient time for the participants to review the transcript of the first interview and make any deletions or amendments. This gave the participants a chance to reflect on what they had articulated in the first interview in terms of their understanding of their role in the curriculum reform process and on both what and how they felt about the roles they played. The scheduling of the second interview *after* the AMC visit meant that this meeting could capture the participants' reflections *following* the very busy phase of the project in the lead up to that visit.

In the second interviews I used prompts such as photographs, media stories, curriculum maps or reports to facilitate recall and promote discussion around key aspects of the project. The focus of the second interview was to ascertain what sense the participants made of their involvement in the reform process, in terms of what they felt about it, the value it had for them personally, the challenges they faced and the obstacles they overcame. The second interview was then focused principally around the next study aim, namely to elucidate the different ways of sense making by curriculum reformists in a medical school. Example questions included:

- *"How did you feel when we presented this to the Faculty?"*
- *"What was this part of the project like for you?"*

- *"What were the challenges you faced?"*
- *"What particular obstacles did you feel you needed to overcome?"*
- *"What was your reaction to this newspaper article?"*

The purpose in conducting two interviews was also to capture the lived experience of change *over time.* Peshkin (2001) argues the need to recognize the "non-static nature of events and people" (p.243) and warns against the snapshot image which may mislead and fail to capture the variability of staff over time:

> A snapshot image may indeed capture something that once existed, but it may mislead and falsify by the extreme narrowness of its representation. To do justice to the variability of teachers... we must perceive them over time. How long, how often, and when to look is a matter of judgment about what might be sufficient. (p. 243)

Some of the questions in the second interview focused on this temporal aspect:

- *"In the last interview you described... What was that experience like for you? Have things changed for you since then?"*

In this way, the chronological aspects of the lived experience were explored.

My Own Reflective Journal and Field Notes

Throughout the period of the project, I kept a journal capturing what were for me critical events in the curriculum development process. In this journal I also recorded my own reactions to what was said immediately following each of the interviews with the participants. These reflections were focused on how I saw our accounts as differing or being similar and what my immediate reaction to the others' accounts had been at the time. This journal also included my response to conversations and meetings with the various other "stakeholders" I met to negotiate aspects of the new medical curriculum over the course of the three years, such as this reflection immediately following a presentation to members of the local teaching hospital:

> *It is the 9th of May and on the 16th the Australian Medical Council visit commences... I have decided to travel to North and North-West campuses... the main purpose of my visit is to ensure that all the key stakeholders in particular*

have been informed about their part in the accreditation visit next week. The School Executive committee met last Wednesday afternoon to consider individual responses to AMC questions that were likely to be posed at next week's visit and I have been singularly impressed with the way that senior academics are pulling together when in this time of need. On the other hand, I was dismayed by the response I received when I presented to the Grand Rounds, a weekly clinical gathering of mainly physicians, at which I presented briefly on the proposed visit and the outline of the new curriculum ...the key unresolved issue for this audience remains whether ...certain representations might be put forward...to the AMC namely that there were still a number of serious obstacles to implementing this new innovative curriculum. I was particularly disheartened...It seems that despite our best efforts we haven't brought everyone along with us on this journey.

(Personal Reflective Journal May 2005)

Or this reaction to a comment from a fellow delegate at a national Medical Education Conference in March 2005: (This delegate had heard of our efforts to introduce a new curriculum at SoM and commented to me that we ought not be so worried about whether or not we secured accreditation with the AMC but rather we should concern ourselves with what we do *when* we get it!)

This comment I found quite sobering suggesting the potential inevitability of a successful accreditation result for us particularly given the recent demands being placed upon the Australian Medical Council i.e. numerous medical schools seeking accreditation simultaneously to meet the real medical workforce shortage in Australia. This is in itself problematic as it threatens I think to undermine the quality of the accreditation process. I am now beginning to be concerned about the possible scenarios that lie ahead:

- *1. We get accreditation, but for a defined short period of time, and suffer the consequences of a return visit and all the work that that entails a year or two later, whilst at the same time expected to undertake the very significant challenge of implementation and evaluation.*

- *2. We get accreditation, for the time that I hope we will, namely two years removing the external driver of change during this timeframe with an inevitable withdrawal of support and resources: support from the Faculty (already feeling fatigued from an arduous process of preparation for this accreditation visit) and resources from the policymakers and University hierarchy.*

- *3. We don't get accreditation, owing more than likely to perceived insufficiency of our resources than insufficient preparation and we have to then try to explain this to an already cynical set of stakeholders.*

(Personal Reflective Journal March 2005)

These personal reflections throughout the period of the study and immediately following each of the interviews address the other research aims; namely to share my personal lived experience of curriculum change and the meaning I attribute to that experience, to use my own story of situated lived experience of leadership of curriculum change to explore my *sense making* over time and to demonstrate the complex interaction between my experience of change and others'. Using the reflective journal over the course of the study I have incorporated self narrative into the story as a means towards greater reflexivity in my practice as an agent of change.

Informal Interviews with Former Deans

In considering how best to contextualize current stories of change I discovered that all but one of the former Deans of the SoM was still resident in Southern State at that time. I wondered whether their stories of attempted and successful curriculum reforms would resonate with my own and those of my colleagues currently working on the 5-year curriculum project. I saw their stories as potentially providing a useful backdrop to the modern day perspectives and providing the study a useful temporal dimension of continuity (Connelly & Clandinin, 1990) in a single institution over time.

The former Deans' interviews took place in September and October 2005. One of the Deans required my traveling interstate to conduct the interview in his rooms. A single interview was conducted with each of the Deans. The approach to the interviews and questioning was similar to that described above. Questions were designed to establish the particular key curriculum related events they had encountered as Dean and importantly how they felt about those events. Again I used prompts such as photographs, media stories or reports and archived documentation to facilitate recall and promote discussion around key aspects of curriculum reform during of their tenure as Dean. All of the Deans were open and candid about their successes as well as their failed attempts to introduce curriculum change and had carefully reflected on the reasons for these in the intervening years. Some still harbored deeply felt emotion about their lived experience of change. Clandinin and Cave use the metaphor of "laying" stories alongside those of others (2008, p.770) so that the resonance between stories can be

explored. Bateson (1989) also writes of the need to look to other stories so we can "test and shape our own" (p.16). By laying the stories of former Deans spanning the School's 42-year history alongside my own and those of my contemporaries, I sought to make personal sense of the events of the past three years.

Documents and Other Unobtrusive Data

In addition to interviewing key participants in the curriculum reform project, recording my own personal reflections during the period of the study and interviewing former Deans of the medical school, I sought to buttress this with other sources of data which were collated throughout the period of the study. I collated all of the documentation generated by the New Curriculum Working Group during the three year study period. This included curriculum plans, minutes of meetings, newsletters, correspondence to and from the Australian Medical Council relating to accreditation, photographs taken relating to the new curriculum and media stories. Hatch (2002) refers to this sort of data as "unobtrusive" as the collection of such data does not interfere with the "enactment of that social phenomenon" under study (p.116).

Prior to interviewing the Deans I also conducted a search of the State Archives office for relevant documents pertaining to each period of Deanship. This search was informed by my reading of the only historical account of the School (Rand & Kirkby, 1990). During the course of my interview with the oldest Dean he handed me handwritten notes which were his reflections on the history of the School during the 1960s.

The specific data collected over the period of the study are listed below:

Summary of Text and other data collected between October 2002 and November 2005:

- Minutes of all NCWG planning meeting conducted
- All correspondence generated by author relating to the new curriculum
- Minutes of all Medical Education Committee meetings conducted
- All written submissions to and reports from the AMC
- Discussion papers generated by the NCWG
- Proceedings of Curriculum Forums held
- Summaries of all workshops held
- Project plans and timelines generated during this time
- Medical School, University and public media press releases relating to the development of the new curriculum
- Feedback and evaluations received relating to the development of the new curriculum
- The monthly MEU newsletter "*Catalyst*"
- Photographs of meetings, workshops and key events
- Archived correspondence relating to curriculum matters and the Schools beginnings dating back to 1957
- Hand written historical account of school's beginnings by former Dean

Table 2. Summary of text and other data collected.

Searching for Meaning

Once I had the transcript data entered into a computer software I then set about analyzing the data in a "systematic search for meaning" (Hatch 2002, p. 148).The approach I used for analysis was informed by Hatch's eight-step "interpretive analysis" approach (2002) as well as Muller's work in the health setting (Muller, 1999). Muller describes "entering the text" using some mechanism for coding, followed by "sense making" or finding links between the data:

> The first step is *entering the text*, either through the application of a pre-established coding scheme or by sifting and sorting the text to identify categories most pertinent to the research question. Once the researcher has entered the text, the process of *sense-making,* or finding connections and relationships in the data, begins. These links are not made through statistical manipulation of the variables but from successive readings, critical reflection, and persistent immersion in the text. (p. 228)

Referring to the analysis of illness narratives, Muller (1999) argues the emphasis is then on "discovery of themes or patterns in the texts" (p. 229). Muller then refers to the next and final step of "*verifying* or *confirming*, to achieve internal consistency of interpretation" searching for alternative explanations and ultimately "as the researcher repeatedly immerses him- or herself in, and then steps back from the data" the represented account is put forward (p. 229). I listened over and over to the tape recordings, reading and re-reading the transcripts for "a sense of the whole" (Hatch, p. 181). After listening to the interviews I also read and reread comments that I had made immediately after each of the interviews as well as my own written recorded journal entries. I looked for particular issues or themes and I also searched for dissonance or resonance in the different accounts. Some of the memos I wrote during this process and highlighted areas lead to a reread of other interviews which in turn shed light on new themes.

Restorying

Having immersed myself in the data searching I then began what Wolcott terms the "mindwork" (1995, p. 233). I was aiming for a holistic and comprehensive analysis of the texts (transcripts and documents), and not simply thematic development. I analyzed the stories, searching for elements such as place, plot, protagonists and predicament and then rewrote the stories within one using a chronological sequence.

I began to consider how best to reflect the myriad of themes that emerged. I did not want to lose the temporal aspects that permeated each of the stories and so I sought to maintain this perspective in the retelling. The stories each had a past, present and in some cases future. A chronological sequence also resonated with the context in which these stories took place. Cortazzi (1993) suggests that it is the chronology of narrative studies that set them apart from other types of qualitative research. In his writing about schools, Peshkin (2001) refers to schools as "places of clock and calendar" (p. 243). In every school there is for instance the school year, which Peshkin says "immediately calls our attention to time...within the year...there are other time frames-semesters, grading periods... In short, there are various framing segments within which to follow events and actors" (p.243). The academic life at SoM, like any other educational institution, was also arranged around teaching timetables. The curriculum design project also had

clear temporal limits. October 2002 to November 2005 represented the period in which the planning for the new five-year curriculum took place. The academic year determined individuals' capacity to make a contribution to the project as they juggled other undergraduate teaching commitments. Most meetings were scheduled around the weekly timetable and the annual curriculum planning forums were also scheduled around semester breaks.

Another important factor in the restorying was to present the voices of my colleagues and my own voice concurrently. By interspersing all of our different voices in the text, the many issues facing us were articulated in chorus so as to reproduce the layered, multidimensional nature of lived experience. The polyphonic nature of the text brought my voice into the contrast with other voices past and present, so that multiple perspectives were laid out like a tapestry which I then used to help me define, place in perspective and understand my own story.

Peshkin (2001) argues the need to recognize the "nonstatic nature of events and people" (p.243) and warns against the snapshot image which may mislead and fail to capture the variability of staff over time. By capturing the accounts of the former Deans stretching over a time frame of 38 years this study allowed the lens to focus in and out over this time span, from the school's beginnings in 1965 to the eve of a completely restructured curriculum in 2005, illuminating the continual movement and variability of people and events over time. The perspectives from the past also helped me avoid what Peshkin (2001) describes as "the arrogance of presentism". (p. 243)

The approach used in this study is reminiscent of the holistic approach or "three-dimensional space" approach described by Clandinin and Connelly (2000), in which there are three defined aspects: interaction, continuity, and situation. The interaction is the analysis of the text to uncover the personal experiences of the storyteller; continuity refers to temporality, i.e. the researcher considers the present, past and future of the story and storyteller and situation refers to the context or place of the story, i.e. the researcher looks for "specific situations in the storyteller's landscape" (Ollerenshaw & Creswell, 2002, p. 339).

I took a closer look at the events that marked the time frame October 2002 to November 2005 and divided the 36 months into four distinct phases. Although these four phases could be described in terms of the first of Rogers'(1995) two-step process i.e. *setting the change agenda* or the first two of Levine's four-stage process description (1980), i.e. the phase in we *establish the need for change* and the *planning phase*, I found neither description adequate in terms of what actually transpired in the three years of the study. A more comprehensive representation emerged from my analysis of the narrative collated.

The first nine months was on reflection a period of "getting underway". It represented the time when the members of the NCWG were forming working relationships with each other and with other members of academic staff in the School. This was the time of developing the project plan, establishing timelines and forging networks with colleagues across the State. It was simultaneously a phase in which we sought to establish the need for change and a phase of planning. The second 11 months was marked by a period of proliferation of documentation as well as a growth in the number of committees and sites of curriculum reform activity across the three campuses of the school and could best be described using the metaphor "growing pains". This was a phase in which we continued to seek to convince colleagues (and ourselves) of the need for change as many staff remained ambivalent about the need for reform half-way through the project.

The next seven months represented the most difficult time of the project with turmoil within the NCWG and a real sense of the project being "under siege" both from within the NCWG, within the School and from without the School. The final 11 months represented the busiest time frame, culminating in the AMC accreditation visit and the handing down of the final accreditation result – best described metaphorically as the "race to the finish". Each of these four time frames, although not the same duration, was defined by an identifiable plot characterized by a beginning, followed by a period of complication and then a period of resolution.

The Four Narrative Chapters

The four phases of the project formed distinct temporal limits within which the characters – past and present – were then "situated" to articulate their experience of curriculum reform, both personal and professional. The representation of the data allowed the lens to move between characters and across time, simultaneously.

Within each of the four time frames (chapters), I chose events which had a particular bearing on the curriculum change process. These were events which did some or all of the following: represented significant milestones, caused confusion, galvanized opinion, created contradiction, separated individuals or evoked an emotional response. They were events which created an entry point for other participants' voices.

By way of example, the first nine months, *getting underway*, was divided into the three discrete sections of an introductory phase, and a period of complication followed by a period of resolution. The story of each of these three phases was told using narrative from a variety of the described sources. In the introductory phase I grouped events and issues such as my own arrival at the school, the NCWG becoming established, the formulation of the MEU strategic plan and a staff development plan to support the proposed curriculum change and a communication strategy that would reach and engaged all three clinical schools. In the period of complication I grouped events such as seeking to convince people of the need for a new curriculum, feeling personally overwhelmed by the demands of numerous external committees and stakeholders, feeling the pressure to continually find evidence to support the need for change and looking for support for the project amidst the confusion of altered governance structures in the School. In the final, resolution phase, I grouped forging links with other faculties outside SoM, supporting staff with seminars, workshops and guest speakers and culminating in the first school wide annual Curriculum Forum.

Having defined carefully the salient events within each of the four time periods (much like the four quarters of a clock face), I then returned to the data, transcripts and other unobtrusive data I had collected and arranged these around the same "clock-face". The narrative accounts of the participants as well as the accounts of past Deans were "retold"

in the chapter in which they had *most* resonance. In this way I sought to "restory" the participants' accounts and place them within the context of a familiar chronological sequence and spatial setting. To reduce duplication in the stories told to me by other participants, I selected the voice that best articulated the event and the experience as lived relating to that event.

Challenges Posed in this Study

At the outset of the study I felt the burden of responsibility which Becker and his colleagues (1961) referred to as the "double duty" – I felt I had the responsibility to the so-called "profession of social observation" (p. 15), to recount the events accurately and to "restory" faithfully – but also to the participants of this study who allowed me to tell their story. To this can be added the sense of responsibility I also felt to the students of this curriculum and the local medical profession, indeed the whole community, not to diminish the esteem with which most held the Southern State's only medical school. Describing the approach used in *Boys in White,* Becker and colleagues (1961) describe the balance they sought to achieve in their reporting:

> We do not report everything we observe, for to do so would be to violate confidences and otherwise do harm. On the other hand, we must take care not to bias our analyses and conclusions. Finding a proper balance between our obligations to our informants and the organization, on the one hand, and our scientific duty, on the other, is not easy. (p. 15)

As the stories, including my own were shared, I became less concerned about the risk of causing such harm for I recognized that I served everyone's best interests by delivering a faithful account of all of the stories. Each account was supported by and connected to another as in a tapestry and so, when examined carefully, it revealed many facets simultaneously. To unpick any of the threads to "make tidy" would be to unweave and undermine another account and so on. As McDermott and Varenne (1995) point out, each story was "made significant by others, only sometimes being the same, more often by being different, more dramatically by being contradictory" (p. 326).

Although I felt initially awkward immersing myself in the text, owing to a lengthy immersion in the more familiar positivist tradition, nonetheless I came to understand that it was *not* necessary to step aside from the community in order to study it. Instead of trying to continually compensate for potential bias I came to rely more and more on my own voice which over time provided the means to reflect personally and professionally on my own lived experience of curriculum reform. Ensuring a significant and ongoing place for my colleagues' voices as well as the voices of former Deans attended to matters such as fidelity, authenticity and adequacy (Hatch, 2002, p. 129).

A related tension I experienced at the outset of the study was that of resisting making links between the small sample size of the study and the larger population of medical educationalists. This was another legacy of my previous research tradition. I again came to reject the notion however that I needed to generalize my findings as I explored the place of narrative inquiry in showcasing uniqueness and difference by foregrounding the particular rather than the general and in so doing validating and upholding the elements of experience which are individual, unique, idiosyncratic and distinctive. Polkinghorne (1995) describes narrative reasoning as "a collection of individual cases in which thought moves from case to case instead of from case to generalization" (p. 11).

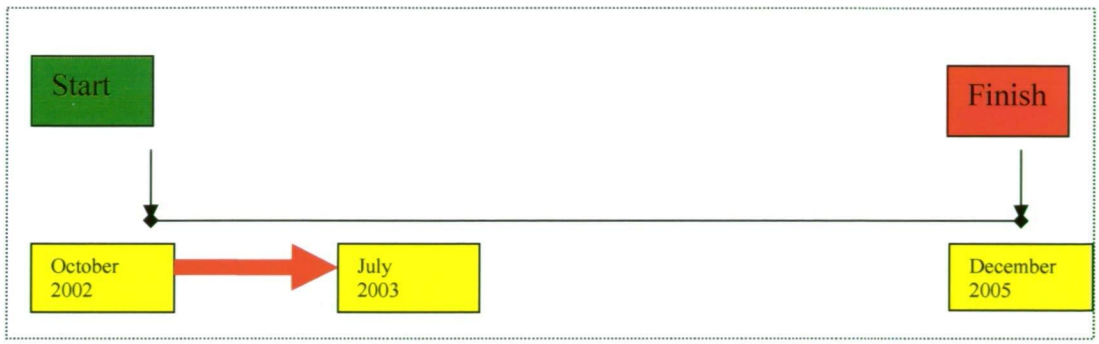
Another tension which existed for me as researcher was the infinite possibilities presented by narrative inquiry. Chase (2005) refers to "narrative elasticity" and the range of "narrative possibilities" in any particular setting when combined with altered social and historical conditions as being "potentially limitless" (p. 667). As my own story unfolded and as I listened to other accounts of the same events I understood that there would always be another way of telling and another way to re-story these accounts. The endless number of possibilities is reflected both in the continually changing landscape in which we live and experience and in the potential for individual growth and transformation that narrative inquiry offers us. Through the telling of our stories about lived experience, in this case of curriculum change, we are transporting ourselves from one place, time and mindset to another which itself holds endless possibility for new stories.

The following six chapters describe the journey through three years of planning in a medical school that has taken the decision to radically reform its 38 year old medical program. This journey is told principally through my voice as the coordinator of the reform project in my capacity as the foundation Director of a recently established Medical Education Unit. My story is intentionally interrupted by the voices[12] of my colleagues encountering the same events over the same time period as well as the voices of former Deans of the one medical school since its inception 38 years previously. These are all the voices past and present of senior members of faculty charged with defining the vision, planning and implementing significant reform of a traditional medical curriculum.

[12] This font is used to reflect my colleagues' voices.

When I reflect on what was said by my colleagues I use this font.

Chapter 4 – Getting Underway



Late Starter and a Confused Beginning...

I commenced in October 2002 as the Coordinator of Medical Education at SoM, a newly created position established in response to the previous year's AMC findings (Australian Medical Council, 2001), and seen as part of the School's strategy to support the development of a new medical curriculum. A month after I started, the AMC extended accreditation of the existing 6-year medical course for three years to December 2005. This decision was subject to receipt of satisfactory annual reports from the School. At this meeting the AMC also endorsed the School's plans to develop a new five-year degree course, subject to satisfactory receipt of ongoing progress reports regarding the same but with the caveat, however, that the School defer commencement of the new program until 2006. It was felt that the proposal to develop a new medical program, as well as implement the significant changes recommended in the last report by February 2005, was overly ambitious. Although I was aware of the many recommendations of the 2001 report, I felt the decision to defer commencement of the new program for a whole year was overly cautious. Certainly there was a lot to do; however, it seemed to me the original timeframe was entirely achievable. I nonetheless accepted the decision and moved into the planning phase with what now seemed a generous allocation of time.

The position promised to be interesting as it involved establishing a new Medical Education Unit, coordinating a major project and change management. I was fresh from an MBA and recent Fellowship in Medical Administration, and this was just the sort of

hands-on change management project I relished. I recall sitting in my office the second week drafting the first of many project plans and listing the people with whom I should contact and establish a working relationship. It was a difficult time of the year to commence a new appointment. October is the second last month of the southern hemisphere academic year and it all seemed quiet on the top floor of SoM. Few people seemed aware of my presence down the long corridor past the Dean's Office to the MEU, where I was housed. To complicate matters, the Project Officer assigned to the Unit was located in a neighboring building connected by a series of lifts and external stairwells. It seemed a long time between the scheduled school meetings to which I was invited and which were wrapping up for the year, but I was determined to make a start before the year's end and get to know the people I would be working alongside.

I distinctly remember feeling the need to make myself and this new unit, consisting of myself and a part time project officer, valued and useful. I was mindful that this medical school – my alma mater, had been graduating competent medical practitioners for nearly 40 years and that the addition of an MEU, which did not contribute to teaching directly, to an already "under-resourced"[13] medical school was not likely to be perceived as a helpful addition.

My personal vision for the MEU, which I hoped would grow in size as the curriculum development project got underway, was about "coordination" and "support" of the School's medical education mission, but I soon found the need to reinforce this message to colleagues. As no such unit had existed before, some of the requests I was starting to receive were purely of an administrative nature. I wanted no unrealistic expectations lingering at the start of the next academic year as to what one full time academic and a part time project officer might be able to deliver. I felt I needed to communicate clearly my interpretation of the specific role of the MEU as well as set about doing something practical and constructive which would establish the credibility of the unit. Modeling this new unit on other Medical Education Units across Australia and New Zealand, the

[13] The 1998 and 2001 AMC assessments raised as one of the issues the need for appropriate human and other resources to support the curriculum.

key portfolios which I felt confident could be coordinated from the MEU were *Curriculum Development, Staff Development* and some targeted *Curriculum Evaluation.*

A curriculum working group had been appointed in the months before I commenced, ostensibly to "brainstorm" the new five-year curriculum; however, there was no written record of any plans and no one seemed to have a defined coordinating or leadership role. This seemed to me the obvious place to start.

Team... What Team?

My first plan was to gather together the five members of this recently appointed curriculum working group. The team consisted of a full time physiologist (based in a neighboring medical science campus 5km away), a part-time palliative care consultant based in the northwest of the state (over 200km away), a respiratory physician (located on the next floor down from my own office), an emergency physician (who was about to travel to the Antarctica on a six week expedition); the half-time project officer attached to the MEU and now myself. Collectively we had many years of experience in medical education and three of us were pursuing formal post graduate qualifications in Education. However, none of the other members of the group had been provided with any backfill or relief from existing teaching or research responsibilities to participate in this major project. Although this was a concern to me, there was little they or I could do as teaching remained a priority, particularly with growing student numbers.

I decided to take a risk and send out what to me represented a landmark communication to the other members of the group. I was conscious of the timing as this was now the last few weeks of the academic year. This first correspondence was an attempt to formalize the activities of the curriculum development group and to take gentle control, for the group seemed to me leaderless and without clear direction.

My somewhat austere first communication sought ideas for discussion. I had plenty in mind. For a start we required terms of reference, a project plan detailing the key project outputs with key performance indicators and a timeline for the activities we would coordinate and undertake individually and as a group. I suggested we call ourselves

simply the New Curriculum Working Group (NCWG). Our first task, I suggested, should be to set to work on an agreed list of the attributes or the "profile" of the ideal medical graduate. I felt that the Outcomes Based Education (Harden, 2002;Harden, 2007 (a); Harden (b); Harden (c)) approach to medical education seemed not only intuitive but would engage us in a debate which would require both our working together for the first time as a team but also reaching out to the rest of the school in defining this important end point for the new curriculum. What sort of graduate did we want at the end of the new five-year medical program, what were our existing strengths and how could we build on these? What did we want our medical school to be known for? As an approach I felt we ought to pool our resources. I proposed the MEU would be an ideal "clearing house" for discussion papers and key contacts identified in other medical schools in Australia and overseas. I also proposed fortnightly meetings which would alternate with the School's monthly Medical Education Committee (MEC) meetings, allowing for two meetings' worth of ideas to be presented for comment to the MEC each calendar month. I also proposed we use the down time of the summer months to get started.

The single response to my request for other agenda items arrived the day before our scheduled first meeting and was more sobering than I had expected. Without salutation it read: "It might be worthwhile considering why there has been little progress in curriculum development to date, given the AMC have been giving us the same message since 1991." Whilst I had expected some resistance to plans for the new curriculum, it was the extent of the negativity towards the new curriculum from within this planning team and from other senior faculty that surprised me. In a recent meeting with a senior member of faculty (also a former teacher of mine) to canvas his support I had encountered similar pessimism. This senior member of faculty had offered his commiserations for the impossible task I had accepted and reminded me that many before me had tried, and all had failed, to introduce significant curriculum reform at SoM. He added with sincerity that a place of refuge was always to be found in his office and his counsel available to me should the task ahead prove overwhelming. I was initially taken aback at this lack of confidence in the curriculum reform project which seemed to me to be the single most significant undertaking in the school's history. I was

even more perplexed that given his role as a senior member of faculty acting presumably in the best interests of the school he was not a staunch supporter of the curriculum reforms proposed. These were reforms which it seemed to me (and had been presented to me at my selection interview), to be the school's only hope for a viable future. I was on many subsequent occasions to witness what seemed to me a paradoxical public proclamation by members of senior faculty of the need for curriculum change, but a private denouncement.

I certainly didn't want to start off this way; I was feeling positive, hopeful and optimistic about the success that lay in waiting. What this message pointed to was the issue of the School's hitherto apparent failure to take the education reform agenda seriously. I chose not to take issue with it, regarding it instead as an unhelpful start to an otherwise promising journey.

With this single reply to my emails, I wondered if all five members attended that first meeting on the 20th November 2002, one month after I commenced, just to lament the enormity of the task ahead, but attend they did and a few days later I was distributing the minutes and circulating draft terms of reference for comment. We were off and running. I chose to ignore the body language of the first few meetings, the folded arms and the frustrated expressions as I tried to dodge continual references to resources. I simply asked as the self nominated Chair that we look to our terms of reference rather than to the issue of the School's resources, as that was our designated brief.

In November 2002 the Australian Medical Council announced formally its decision to extend the School's accreditation for a further three years and recommended deferral of the start of the new program until 2006. It was at this time (two months after I arrived) I decided to deliver my "inaugural" presentation to the School as part of the first in a series of what I decided to call the Medical Education "Seminar Series". About half a dozen academics attended that first presentation, which I used as an opportunity to share publicly my vision for the MEU. I spoke of the role of the MEU as being there to work *with* staff of the School of Medicine on pedagogical issues, curriculum design and evaluation and staff development to improve the quality of teaching and learning at

SoM. I emphasized the statewide responsibility of the MEU, and the fact that coordinating the activities of the NCWG was the current priority task of the unit. I described the strategic plan for the MEU which was soon to be launched on a soon to be developed web site and of using this web platform as part of an overall communication strategy about the developing new curriculum. I articulated my personal approach to change management in terms of the need for open consultation, setting clear objectives, an effective communication strategy and the need to manage uncertainty. I spoke of my personal desire to respect tradition (acknowledging that I too was a graduate of SoM) and not wanting to "lose the baby with the bathwater" as we developed the new course. With very little by way of response, I decided to conclude with my interpretation of the task that stood before us in November 2002 which was to document (for the Australian Medical Council) our plans for the new five-year undergraduate entry medical program, in line with their guidelines. The first milestone would be the submission of a Preliminary Submission due in September 2003, the results of which would determine whether we would be invited to continue with the plans for the new curriculum. I took the silence that followed as indicating no major objection to what I proposed. However, I was taken aback at the lack of robust engagement, including from members of the curriculum working group, with the substantial matter of a new curriculum.

By the end of 2002, some three months after starting, I had sent out the inaugural newsletter of the MEU. Entitled *From the CME's*[14] *Desk*, it was designed to allow all staff in the School to keep pace with the ideas that had slowly begun to emerge from the NCWG. In the early months I received no comments or feedback about the newsletter which I was assured was reaching the desktop of every full-time member of teaching staff at SoM. At times I felt like the editor of an illicit newspaper sitting in a bunker trying to keep the troops on the frontline informed and positive. Nonetheless I was enjoying working with an empty canvas. Sooner or later, I felt sure the feedback would start to arrive at our doorstep and constructive engagement would begin.

[14] CME= Coordinator of Medical Education

Building Relationships Within and Without

I was careful not to over-commit the team. The terms of reference therefore made explicit our relationship with the overarching Medical Education Committee (MEC), which was the School's established committee for all matters relating to teaching and learning and to whom (it was agreed) we (the NCWG) now reported. These terms also made clear we were small (in number) and would therefore be "enlisting the support and expertise of individuals and groups both within the School and externally" to assist in this project (Minutes of Medical Education Committee, 2003). A last minute amendment we made to our terms of reference acknowledged the constraints within which we were expected to operate and our "lack of control of resources tangible and intangible". I felt in so doing (at the risk of sounding too formal) we were making explicit the fact that we were developing a new medical curriculum in the context of tight fiscal constraints, that separate resource impact analyses for the delivery of the new program would be required, and that this aspect was outside our remit.

In my capacity as now endorsed Chair, I submitted our terms of reference to the MEC for approval and ratification along with the first draft of our project plan. I looked forward to the opportunity to officially commence the project and the discussion this document would instigate. Despite the considerable time it had taken myself and the group to prepare both documents all they received was a brief statement of acceptance by the Chair with a sobering reminder that the MEC's own terms of reference did not extend to matters "financial" and that these ought to be placed before the School's Executive Committee. As the membership of both committees was almost identical I interpreted this as a caution not to lean too heavily on the MEC for the "input" we had referred to in our terms of reference. Although I acknowledged that an "arm's length" approach by an overarching committee was an entirely acceptable management style, I had not envisaged being left completely on our own – particularly with such a small group and such a significant task. For the first time, three months into the project, I began to ask myself who really wanted this new curriculum to happen.

The Honeymoon is Over

We had been given license to develop a brand new curriculum which would train medical graduates at Southern State for the 21st century. The starting point I had

suggested was an agreed list of the knowledge, skills and attitudes required of the SoM graduate. We were all well versed by now in the work of the UK General Medical Council *Tomorrows' Doctors,* and one of the group had a particular interest in the work by the Canadian CanMED project. I myself spent some time in the summer of 2002/2003 in the Special Collections section of the SoM library dusting off rarely handled works by Sir William Osler and Weir Mitchell on the "ideal physician" and ensconced in the works of great physician writers such as Anton Chekhov and Arthur Conan Doyle. Numerous lists of competencies started to emerge from the NCWG with continual discussion around what we saw as the vision for our new graduates and indeed for the School.

The AMC also required of us a "mission statement" for the new curriculum in the Preliminary Report, and this proved a much greater challenge than gaining consensus on the curriculum outcomes. What we ended up with though seemed to me a somewhat bland declaration:

> The New Curriculum will produce graduates well prepared for internship and with the capacity for further post-graduate training. The attributes of the graduates will ensure they promote the health of their community, emphasising the importance of disease prevention as well as the importance of the individual in the health-care system. (The Preliminary Report to AMC, 2003, p. 16)

This mission statement bore no witness to the many hours we spent on this agenda item in my office. In trying to objectify the qualities of the ideal SoM graduate and somehow rank the more important of these in our mission statement, it seemed we were in fact trivializing them. This was the first matter over which some of us including myself agreed to disagree. I accepted we had been given license to be visionary but I began to question our pace and felt we were also expected to be realistic. One of us had to take responsibility for translating our myriad ideas and plans into a document for circulation. These words, as on this occasion of crafting a mission statement for the new curriculum, could never be expected to succeed in capturing *all* of our vision. As chairperson I suggested therefore we move on to the next milestone on the project plan. Papers were shuffled in silence but move on we did. It was evident to me the honeymoon phase was over and for me too the dalliance with Chekhov had ended.

At least the volume on the fourth floor had been turned up. Faces sometimes looked askance as we emerged one at a time from the office on the top floor of the medical school to refill coffee cups or print out documents. I often left the door of my office open during meetings to not only provide some ventilation as we were crowded around a small desk in limited space, but also to announce to passers-by that serious business was afoot within, which was to alter irrevocably the 40-year medical curriculum.

The silence outside the MEU office, however, concealed a sinister adversary. Convincing colleagues about the value of this work would take time. It seemed for every hour the NCWG spent in my office debating the new curriculum, an equal amount of time was required outside the office communicating with colleagues. I often asked myself how much consultation would suffice, especially as achieving consensus amongst ourselves was already proving a challenge. Nonetheless, the newsletter continued each month and the website was filling with regular postings of our discussion papers. Both received no more than the occasional comment from our readers across the four campuses; often a passing reference to a grammatical error that had been spotted!

Trying to recruit extra support was a challenge. The altered governance structures introduced in the months before I arrived announced the end of departmental and discipline based units. Members of staff were now expected to identify with the year groups in which they taught, i.e. they either "belonged" to the first two years, the middle two years or the final two years of the six-year medical teaching program and (importantly) budgets. Some were already beginning to wonder how this new governance structure would play out when the proposed five-year program began, given its odd number of teaching years. To complicate matters, the announcement in 2003 of the allocation of an extra 21 publicly funded places in the medical school for 2004 was creating much anxiety for teaching staff. Despite this concern about sustainability and overstretched resources, this news was hailed publicly as "good news" for the School and consistent with the University's "growth agenda". Few were interested in engaging in the development of the new curriculum, with its so-called better integration, problem-based learning and proposed small group teaching methods (we were advocating no more than ten students per group), when there were more immediate concerns such as

coping with the additional teaching load imposed for 2004 and the impact of "teaching out" the old curriculum as well as the proposed new program from 2006. There were so many questions we as a group could not answer, and invariably they related to resources.

For the NCWG, the decision to start with the medical graduate "profile" turned out to be a good place to begin our work. It was a topic about which we were all passionate and we each had something to say and so gave us a focus around which we could form a hopefully cohesive group. For instance, the physician in the group focused our attention on the need to measure clinical competence and ensure problem-solving skills were taught in the curriculum. The palliative care specialist was most interested in ensuring graduates were compassionate as well as competent and capable of working as effective members of multidisciplinary teams. For my part a working knowledge of medical error, understanding how it occurs and how to avoid it particularly through improved communication skills was a key contemporary issue which I felt this new curriculum ought to address (no doubt shaped by my recent experience as a hospital administrator addressing complaints often related to poor doctor-patient communication skills).

Slowly the pedestrian traffic flow down the corridor to the MEU office started to increase. Within a few months we were meeting each fortnight and the small oval desk in my room was covered with hand written and typed notes, files, books and used coffee cups. Across each of the whiteboards in my office in different hand-writing were references to elements of specific competency frameworks including CanMED and "Tomorrow's Doctors" as we each took to the floor to convince each other of the merits of our ideas in our small group discussions.

Vision for the New Curriculum

By the end of 2002 the new curriculum started to take form. Having settled on the mission statement, we eventually agreed on five overarching themes which would encompass the knowledge, skills and attitudes which we felt were required of a SoM graduate of the future. We now had our capstone statement of commitment for the new curriculum which articulated what the curriculum promised to "learners, to teachers and

to other stakeholders" (Curry, 2002 p. 1068). We were united in that, although likely to be challenging, our assessment strategies would need considerable reform and should include the "less tangible" aspects of the curriculum such as professionalism and ethics and we would endeavour to find the best way to both teach and assess these important components.

The five themes, which were later assigned "champions" from within the School (all of whom became members of the NCWG), were: Human Health and Disease; Communication and Collaboration; Community Health and Disease; Ethics, Personal and Professional Development; and Integration.

Theme 1: Human Health and Disease

Under this theme heading we grouped both the more traditional scientific elements of the curriculum (e.g. anatomy, physiology and biochemistry) with the clinical aspects (e.g. medicine, surgery and paediatrics). Learning outcomes that were incorporated under this theme included *"Understands the relevance of basic science to the clinical setting"* and *"Demonstrates the ability to systematically elicit and interpret clinical symptoms and signs"*. No-one to our knowledge, had developed a curriculum theme in this manner in Australia. We hoped that in so doing we would ensure better integration between these two important aspects of medical education. Historically these two aspects of the SoM curriculum – the pre-clinical and the clinical – were taught on different campuses and by different staff which in our view had caused an unhealthy and artificial divide between the various academics delivering the program. As I spoke to staff across the campus it had become apparent to me that the pre-clinical teaching staff, who were predominantly laboratory based, rarely communicated with the clinicians, who were predominantly hospital based, and vice versa. Packaging the curriculum in this way and assigning two Theme champions – one a clinician and the other a scientist – to oversee the development (and subsequent delivery) of this Theme was one means of addressing this obvious disconnect. My personal vision was to see surgeon and anatomist, physiologist and physician sitting side by side around the curriculum planning table and then to see such working relationships continued into the delivery phase of the new program. I felt what was needed in the first instance was a greater

degree of mutual respect for each others' content expertise and the contributions each "camp" made to the undergraduate curriculum. This dynamic and relationship between preclinical and clinical medicine needed to be modeled in the interactions between the members of the NCWG.

Theme 2: Communication and Collaboration

This theme would bring together the elements of effective communication skills with a focus on development of effective teamwork and collaboration skills for the healthcare setting. Outcomes here included *"Demonstrates an understanding of the therapeutic relationship between patient and doctor"* and *"Demonstrates the ability to work collaboratively with colleagues in the healthcare team setting"*. No one could dispute the value of these skills in our future doctors. What was hotly debated over the ensuing months was the proportion of time allocated to this theme, as we were under pressure to "make space" for other equally important elements.

Theme 3: Community Health and Disease

This theme was to ensure graduates of the new program understood their role in community health care delivery. Outcomes here included *"Understands the Australian Health care system including funding, planning and priorities"* and *"Understands the social, political, economic, cultural and spiritual factors that impact upon the health of individuals and communities"*. I felt strongly that the potential to develop a rural focus in the new curriculum could provide us with a "competitive advantage" over neighboring medical schools. As both a rural General Practitioner and a regional hospital medical administrator I had seen first hand the impact of the doctor shortage in rural areas and the significant maldistribution of doctors in Australia. We could do more in the new curriculum to provide our students with a more positive experience of rural medicine, particularly as SoM was at the time the most rurally located of all the Australian medical schools.

Theme 4: Ethics, Personal & Professional Development

This theme would focus on the role of the medical practitioner as ethical medical professional committed to lifelong learning. The specific outcomes here included

"Demonstrates a commitment to compassionate, professional and ethical behaviour" and *"Understands the principles of quality improvement, risk management and patient safety"*. Although it was some months before I was able to recruit the support of the School's part-time ethicist to champion this theme, we were all passionate about this dimension to the curriculum, particularly the palliative care specialist on the team. The greatest challenge here I knew would be defining outcomes which we could robustly assess and therefore have them valued by the students as well as staff.

Theme 5: Integration

It was through this theme that the group wanted to make a unique contribution to medical education. I personally doubted the value in naming an individual theme called *Integration* when "integration" was the effect we desired across the entire program, but it was the particular zeal of the physician in the group that won me over and this emerged as our fifth and final theme. Outcomes here included problem solving and critical thinking skills and were phrased as *"Demonstrates an ability to apply critical and creative thinking to a range of problems"* and *"Demonstrates the ability to integrate and synthesize disparate material to arrive at the most appropriate solution to a problem"*.

Each member of the NCWG had different areas of specialist interest but more importantly we all had different approaches to the task. The physiologist who liked to write ideas and was fond of modeling using elaborate flow charts was our "completer/finisher"(Belbin, 1993). The ethicist who later joined the group enjoyed constantly exploring new ideas. Reflecting back on my own style (having also completed the Belbin questionnaire recently) I see that I filled the "coordinator" role. As we became more familiar with each other over time, the energy of the group increased and as individuals we became adamant that our particular area of interest or passion would be represented in the long lists of learning objectives that would eventually become "the curriculum". The discussions were often animated, sometimes quite intense and on occasion hostile. I was not so concerned about the intensity of the group and the fact that we sometimes argued. In fact I saw this as a positive sign for we had

established rules of engagement and as chair I kept the discussion moving around the table to embrace everyone's perspectives. By the end of the first half of 2003 everyone was feeling sufficiently engaged with the project and this I believed augured well for the future and would eventually translate into ownership of the new curriculum.

Inevitable Involvement and Inevitable Revolutions

Simon is the School's Head of Anesthesia and with an established private practice has a busy clinical patient load. Apart from teaching medical students, which he does regularly and enthusiastically, his other key Medical School-related responsibility is to chair the monthly Medical Education Committee. We meet in his office, which strikes me as a rather modest location for the Medical School's only Professor of Anesthesia and Chair of the Medical Education Committee, but Simon seems comfortable in this space. There are no papers on his desk, just a compact laptop which he systematically removes from its case to check the day's appointments. He points out as a matter of course that he is expecting a telephone call about a patient who is due to go to theatre later in the afternoon.

Most people who know Simon admire his work ethic. He moves with apparent ease from the board room discussions to the operating theatre and is as comfortable discussing financial and academic affairs of the School and chairing Medical School curriculum meetings as he is donning his theatre gown and gloves surrounded by instruments, disease and patients.

On the wall behind him hang his qualifications, and my eye is drawn to the crest from the University of Southern State. Despite having worked together for over two years I did not know that Simon too is a local graduate - we share this in common. He casually points out he is in fact the School's youngest full professor. He briefly reminisces during our meeting about his time as a medical student at SoM and in particular his time with the locally renowned Professor of Medicine, after whom the students' main Lecture Theatre was named. Simon's recollections are clearly filled with pride as he insists to me his decision to accept the Dean's invitations to get involved with curriculum reform at the SoM had not been influenced by any perceived deficiency in his own undergraduate training whilst a student there:

> It was still then a fairly small medical school with an intake of 48 and strength was undoubtedly the patient resource. It had good student and teacher ratio- patient to student ratio...that meant you got a lot of experience. It was still a very conventional course parallel to pretty much all courses ... if you were at all inclined the opportunity was there to learn for yourself anyway... I think its ability for people to gain clinical skills was very high through good ratios and a few very interested teachers... so no my spirit for changing medical education doesn't arise from my own poor experience.

After completing his PhD in Glasgow, where he first became involved with curriculum reform matters, Simon returned to Southern State to take up his current post as Chair of the MEC. He did not consciously seek to become involved in curriculum reform at SoM - he was, by his own account, approached because of his recent experience overseas:

> Given that I had that interest (in teaching) that I had experience in the evolution of a problem based curriculum from a conventional one in Glasgow, I think it was very much in the Head of School's mind when I was taken on here... I was inevitably going to be significantly involved if there were going to be serious curriculum reforms.

He also wanted the opportunity to diversify his career. He always knew that as a surgeon there would come a time when he had completed his *"2000 thyroidectomies"* and would think *"Well, what will I do tomorrow? Will I do another 2?"*

> I recognized that I have a low boredom threshold and that I could find that difficult. Whereas academic practice with its research component, its teaching component, even dare I say the administrative component at least offers more variety and is likely to keep me challenged for longer, I thought.

He always saw himself more as a "teaching" professor than a "research" professor:

> Why am I a teaching professor? It wasn't because I didn't find the research interesting. I did a PhD and found that very interesting... I liked to teach as most people did and so being an academic... with a teaching interest at a particular point in time has led to this point but that wasn't particularly an ambition when I was a medical student say.

For Simon the beginning of this journey of engagement in the curriculum reform at SoM was 2001 when the AMC "imperative" for reform came. That visit, which he described in terms of the School having entered a "dark hole", helped to crystallize his thinking *"that something had to be done"*. The metaphor he used to describe the events of that time was one of *"carnage"* with everyone *"sort of lying around ...counting the bodies"* after the AMC had handed down their adverse findings and left the School

to consider the challenges it faced. The key event that followed according to Simon was a Project Management workshop with an external consultant:

> I was one of the School attendees with Paul and Anne... and it was really a discussion after that between the three of us... and we thought okay - would this be an approach to our problems?... And so that sort of crystallized for us that yes it could be and so... we then decided to have a Project Management approach to fixing the things urgently that the AMC wanted. So we really had a sort of one-year plan of how to get ourselves back together for the revisit by the AMC - and that was I think fairly spectacularly successful, as it happens.

His overall impression of the achievements of the NCWG and the MEU since 2002 was that it had merely continued the efforts which he and his colleagues had initiated in 2001:

> No, that's probably been the less arduous period in a way because [by then] it had acquired a momentum of its own... probably was more difficult to get it going... Once it's underway... it has a sort of a momentum of its own.

I'm Not Saying We Didn't Need Change, But...

Simon's indifference to the role of the MEU and NCWG was more deeply rooted. He was unconvinced that the efforts to modify and restructure the undergraduate medical curriculum were going to make a tangible difference:

> I still hold the view... that if you give motivated and bright students the opportunity and don't get in the way too much they will actually get there... most medical education is still post-graduate, always was even in the traditional courses... Mine isn't the general view. Most people I think see undergraduate medical education as a very important building block. I tend to find that it evens out so quickly in post-graduate medicine that I tend to take a different view that it can't be that important because... you can't tell what Medical School they came from after a few years.

Whilst he laboured with us over crafting learning objectives and devising more robust and innovative ways to assess our students' mastery of knowledge and skills, Simon was still grappling with the inherent value of this effort:

> Pragmatically there's a bit of me that recognizes that it all probably doesn't matter very much and it will turn out alright in the end... Academically there's another bit of me that says that if we accept the characteristics we want in graduates are different to what we perceived before... then we should go about the education process in a different way... I agree with that and I think it's challenging and interesting to try and refashion the way we make doctors... [However] I suspect it doesn't make any difference... Doctoring is something

> people pick up along the way and probably always have - and that we could be wrong about the type of doctors we're trying to produce and it's all based on assumptions really, commonly shared assumptions - but assumptions.

Convincing his colleagues across the campus that this significant reform of the medical curriculum was the right path to follow posed a particular challenge to Simon:

> I think you can by and large sell people on the new medical education paradigm. Most people when you explain it to them say yeah that seems very reasonable, that's why we tend to accept those assumptions. It's more overcoming the "it ain't broke so we don't need to fix it" mentality and so I think that's been the challenge.

Reflecting on the quantum of curriculum reform the NCWG had initiated, Simon wondered whether the extensive changes we proposed were really necessary:

> Did it require a wholesale change?... No... there are still conventional courses like [mentions another Australian medical school] - a recent [successful] course built on a very conventional framework.

Whilst he accepted that some change was probably necessary, he was left wondering whether a smaller "dose" of reform might have been equally therapeutic.

At the time we conducted this interview in 2005, Simon and I had worked together side by side for nearly three years. He had accepted my invitation to join the NCWG as Theme 5 Coordinator as he had a particular interest in evidenced-based medicine. Every fortnight we sat with other members of the NCWG around the planning table for two to three hours at a time, meeting for as much time again at the Medical Education Committee on alternate Wednesdays, attending numerous curriculum workshops and forums. It was not until we had this conversation that I fully appreciated the extent of his skepticism about the place of the NCWG, the MEU and indeed the whole reform agenda. In three years Simon hardly ever missed the NCWG fortnightly meetings. I felt he was the group's most senior and respected member and yet it was not until the final year of the three year project that I understood how seriously unconvinced he was through all this time of the role we all played in defining a new future for medical education at SoM. Given his uncertainty

about the work we were all undertaking it was no surprise to hear he found it difficult, especially as Chair of the Medical Education Committee, to convince his colleagues of this radical reform.

The critical time frame for Simon in the history of this recent curriculum reform effort had been the 12 months following the AMC visit in 2001. Yet the only tangible evidence I could find to support any commitment to reform in the immediate aftermath of that visit was a dust-covered project plan which I found by chance as I cleared my new office of old papers in the first month. No one had seen fit to bring this document to my attention. Yet listening to Simon I felt that I was hearing a critical piece of private "corporate memory", of which I had played no part (this aspect I felt was being particularly emphasized to me). Perhaps I had been too hasty in clearing my office and starting again in those first few weeks. There was evidently more attached to that rejected project plan than I had recognized. As I listened again to the words he had spoken of "carnage" and "counting the bodies" in the wake of the 2001 accreditation visit I was left trying to imagine what he must have endured in his role as Chair of the Medical Education Committee. Many of the queries from the AMC would have been directed to him during their week-long visit and he no doubt experienced a sense of failure when their findings were later promulgated. For Simon the decision to quickly regroup and formulate a plan for recovery, of which he played a significant part, was the single most important event of the past five years and not, as I had considered, the establishment of the MEU and the NCWG, which followed 12 months later.

Vision for the MEU

My next task was to relocate the part-time MEU project officer closer to my office. It was already clear to me that the project officer and I would alone shoulder the burden of recording and collating ideas and concepts and that efficient communication between us was essential. There was no shortage of ideas and opinions at the fortnightly NCWG meetings – what was lacking was a constructive mechanism for collating it all. The more I spoke with other medical schools, the more it became apparent I would need to be careful not to over-commit my scarce resource. I managed to enlist the support of the School's two Medical Education Officers (recently appointed positions designed to support the delivery of teaching in the two outreach clinical schools). Although no-one

apart from the project officer and I were formerly attached to the MEU, with some creative use of the term "curriculum development team" the two Medical Education Officers and the other members of the NCWG came to be identified with the MEU, giving the unit a profile within the medical school.

By mid 2003 we were ten in number, although only one of the ten reported directly to me. A lot of my energy was spent cajoling and encouraging this enthusiastic, passionate but at times skeptical and mostly overwhelmed group of academics. Many had supervisors in the School who were even more incredulous of the project and resented the compromised teaching hours this project represented. Some of the supervisors were openly unsupportive about release time for engagement in the NCWG meetings. An attempt to clarify the situation with the rewriting of position descriptions to ensure protected time for curriculum development proved not to be as helpful as I had hoped for. There was no formal recognition of contribution to curriculum development in the performance appraisal system.

Gradually though we began to receive expressions of interest from other staff keen to participate in the curriculum project. For many of these their stay with us was short-lived as they found the additional responsibilities (writing cases, designing new assessments, writing tutor notes etc) onerous, on top of their existing work load. I quickly learned not to take this personally. In fact, apart from the administrative challenge as a new face appeared around the planning table each fortnight, it had the advantage that the project benefited from the albeit transient input of different staff members and everyone could rightfully feel some ownership of the curriculum. I had decided early on that I also wanted membership of this group to reflect a broad range of expertise, some of which was to be found *outside* the medical school. I specifically sought input from other Faculties, experts in law, ethics and psychology as well as lay consumer groups. Some of the more enthusiastic contributors were not from the medical profession at all!

Am I Passionate about that? Well, No...

Not all the members of the NCWG could be described as "passionate". Simon delivered his views and opinions with equanimity. His view was that this new curriculum was a necessary evil and that change was inevitable.

He had a special interest in evidence-based medicine and when asked to join the NCWG as Theme five "champion" he agreed. This was a way in which he could make a more tangible contribution to the development of the new curriculum and stay in touch with the developments, although he was also chair of the MEC. Describing his attitude to all the changes we were planning:

> I'm saying the drivers have changed, there are reasons that we need to alter the type of medical students that we're training but am I passionate about that?... Well no... But then that's just my nature...I'm an intellectualizer rather than emotionalizer... Whilst I can rehearse these arguments at great length I'm not passionate about that. If it all falls over, it all falls over and we'll produce some medical students somehow. You take bright enough young people, give them enough time, send them out to the health care system they'll end up as doctors. I suspect we don't change all that awfully much so I don't envisage disaster at the end of this whatever happens... Am I passionate about that?... No.

Rather than someone who had a passion for change he saw himself:

> as somebody who is comfortable with that change and the rationale for that change, understands that, agrees with it, can, I think, articulate it, am quite comfortable with the idea of advocating it. Am I passionate about it? No, that's like somebody who is interested in the environment but isn't necessarily going to chain themselves to trees. That's the difference and I don't think you need to be passionate about it necessarily. You need some people who are and you need a mixture of people probably who aren't, I think.

A Personal Vision after all

Simon had been a member of several other schools' accreditation teams and had seen all these "lists" before. When he saw our list, he was not surprised:

> I don't think there's anything unique about the product that we're trying to produce. I think if you look at our themes, our graduate learning outcomes they do look fairly similar.

Nonetheless, Simon did have a particular personal vision. If there was to be one single change to this new curriculum, it was that we would graduate doctors who were *"problem solvers"* rather than *"solution rememberers"* and that these graduates would see the patient as belonging to a community :

> That they have a view that extends beyond the narrow confines of the patient sitting in front of them to a community focus... I actually want them to be able to think more about how they as doctors affect the health of communities not just a named patient in front of them and yeah that they're actually able to act in a problem-solving way which is about evidence-based medicine. Can they recognize information, seek and apply information, understand that they don't have a... tool kit that they can take away and use forever? They continuously need to be renewed.

Simon had spent many hours debating these aspects with colleagues and found the "community focus" of medicine the least well understood by students he had taught over the years who saw the Hippocratic Oath as meaning they had to do *"everything we can for all the patients"*. Instead Simon was arguing for an understanding of the overall cost of health care and that decisions about priorities needed to be taken into account when defining a management plan for patients:

> We need to make decisions about who to treat for what... That means trading off one thing against another. To a lot of doctors still this is completely not understood and it seems to me that... it's perhaps the crunch issue in the health care that we face at the moment - is who gets what, hitherto that's something we haven't trained doctors for. It's all been you do everything for the person in front of you as if other patients didn't exist.

One aspect Simon found difficult to embrace was the notion that the new curriculum had to correct some deficit in the teaching of communication skills:

> I know that's supposed to be one of things that the new curriculum is good at... I'm not sure people are ever so bad about it to be honest. That's more the issue, I didn't see it as much as a problem as everybody else...

An Enthusiastic Communicator

Phillipa, a clinical psychologist with over 20 years' experience teaching medical students, did not share Simon's lack of enthusiasm for the teaching of communication skills. Quite the contrary:

> I suppose there are a few things that really have been bringing it home to me for 20 years. I guess one of the things that used to happen every year is that a number of students would fail their sixth year OSCEs[15] and they would have to ...be examined in January before they could proceed to their first post as an intern. And every single year they would fail because of difficulties with communication...I would spend every December and January remediating these

[15] OSCE= Objective Structured Clinical Examination

> students [to enable them to pass this final component of the exit examination] and this became more and more of a problem.

Phillipa became the new curriculum champion for Theme 2 (Communication and Collaboration) in 2004. She was a late entry to the NCWG and was delighted to receive the invitation to join the team. Phillipa had many years' experience remediating medical students who had failed their final exams because they lacked appropriate skills in communicating effectively with patients. She felt strongly about the unreasonableness of failing students over subject material that had never been formally taught. Her contribution would be to ensure an appropriate amount of dedicated space and time in the new curriculum for the teaching and assessment of these important skills:

> Students also said to us privately that whilst it isn't how they wanted to spend their December and January [summer vacation], that they actually valued it because they learnt some things and thought about some things that they had never thought about before and they valued that experience. And so I guess that's always been in the back of my mind for probably the last ten years.

Not all students appreciated the need for communications skills training in the undergraduate curriculum. In her time at SoM, Phillipa encountered what she described as "the most appalling arrogance of some of our students about communication". Where she did manage to include sessions for the students on matters such as "breaking bad news", "communicating with the elderly" or "opening and closing the consultation", typically a significant number of students expressed the view that they did not need special instruction in communicating with patients:

> I actually think they need to be debugged from the start and reprogrammed in a way that is good for them and is good for the way they are taught and matches with how they will be examined. I guess the second level that strikes me a lot as I get older and my colleagues get older and we've all had a whole lot of experiences, is that poor communication is an accident waiting to happen when your job involves talking with people.

She wanted students of the new medical program to appreciate more than ever the impact that poor communication can have on the professional relationship between doctor and patient:

> Well I suppose there are quite a lot of things that rattle around in my head, but I suppose it would be that people appreciate that how they interact with their fellow human beings has an impact on that human being and has an impact on themselves I suppose. I mean I am reminded of something that every mother in

> the world has said to her children and that is it's not what you say, it's the way that you say it.

When we had this conversation I asked Phillipa about her particular medical education passion.

> Well something that I always feel passionate about, it's kind of a permanent passion of mine, is respect, and I really, really hope that... we model that. Because I've been here for such a long time I have, I am sad to say, seen quite a number of students graduate at the other end with entirely repellant behavioural styles and no respect whatsoever for their fellow humans. I actually don't think that's good enough.

On *Not* Being Medically Qualified...

Phillipa is quick to point out that her passion for "respect" has not been as a result of any personal lack of respect shown her by colleague, but acknowledges that campaigning for Theme 2 has *not* been an altogether easy task as she did not hail from the medical profession. She recognizes that her area of content expertise – interpersonal behavior and communication skills – will never achieve quite the same recognition as more established traditional subject matter such as the "good old cell membrane":

> If I'm strictly objective about it I think there are quite a lot of times where maybe the Theme 2 contribution is sort of seen as a bit of an ancillary thing and I think there are times where because I am not medically qualified, people make assumptions about things that are not necessarily correct. I guess at this stage of my life they can stand to be corrected but I'll do it as nicely as I possibly can. So a few times that sort of stuff has come up.

Despite many years of experience teaching medical students, Phillipa had never had the opportunity to contribute to the development of a new curriculum and so the invitation to become involved with the project was enthusiastically accepted:

> I have been involved in teaching medical students for a very long time and it's well more than 20 years and I've taught at both post-graduate level and undergraduate level in the UK and in Australia. So my motivation is strong and interestingly... I think as I've said to you before it is all a bit of a dream come true for me.

She felt the proposed model of distributing the weight of assessment equally across all five themes of the new curriculum was progressive and was excited about the prospect that the theme area she championed – "Communication and Collaboration" – would

finally achieve the status she had fought so hard for over the years. Still she recognized she would need to be wary about ensuring that we all remained committed to this:

> I just think that sometimes people inadvertently just in what they say or what they suggest, I don't think I'm being paranoid and strange about this, I mean 20 years ago I was probably paranoid and strange about it but I am way past that. I just think it is probably fair to say that a lot of people involved in the exercise still have some level of internal struggle about accepting things like themes 2 and 4 and perhaps theme 3 and I am uncertain about theme 5, but they still within themselves have a bit of an internal struggle about sort of seeing it all as being completely equal.

Seven months into the project she is confident it will all work out. But she feels she will need to remain vigilant about ensuring her Theme is valued and delivered:

> Oh it will work, it's going to work. I think I have a feeling that I am going to have to play it fairly carefully. I guess because I've taught for so long in psychiatry I am used to the fact that some students think that when I'm teaching them about things in psychiatry that it's kind of second level teaching, like a nurse or a midwife coming to teach them instead of an obstetrician-gynecologist, so I'm a bit conscious of that. I see that whilst I like being the theme coordinator there's a slight danger in the theme coordinators not being medical personnel in terms of student perceptions, and I think probably the way to deal with that is to make sure that some of the people that deliver the theme's material are in tune with the theme but also medical practitioners.

Dealing with Resistance

During her first year on the project Phillipa developed a sound working relationship with the other non-medical theme coordinator, the School's resident ethicist. Together they worked diligently to represent their theme area(s). This was done in good faith, with quiet determination and with my full support as Chair:

> I think the goodwill between everyone working on the development with the understandable human hiccups is pretty phenomenal. I mean I would have to say it's terrific fun when three or four of us sit down to nut out a problem and work out how it will work. And the other thing that's really very interesting is that almost without thinking about it and certainly without orchestrating it, a lot of us are, we are working in mutually complementary ways by accident. We sit down and say I'm doing this and someone says I'm doing that, someone says I'm doing that, and we all go wow, that just meshes together perfectly.

In her 20 years of teaching she had never experienced such partnership and felt that conveying this to the students, particularly through the use of weekly cases designed by the NCWG, would send a loud message about real "integration":

> *Getting that... across to the students might be the most valuable thing that we can do... That might be something really, really important to hang on to... it's not five different ways of looking at the case, it's being able to explore the whole of the case.*

As she took on the responsibility of talking to more of her colleagues about the new curriculum to "spread the message" she felt her professional background in psychology helped her manage the sorts of opposition she encountered:

> There's a lot of psycho dynamics, there's a lot of territory battles, there's a lot of people that come to the process with wounds and extremely gently without saying very much at all we've moved to the point where at our last meeting we got a bit of a context, we got a bit of an idea looking at years 3 and 4 what bits need to migrate back to year 2 [in the new curriculum]... I need to nail Paul to a chair because he's going to have to pull back clinical skills teaching from years 3 and 4 and put some of it into year 2. It's working quite well, there's a lot of work still to be done to help people move, there's a lot of people who say but this is how we've always done it. It's interesting how resistant people are to change... it's just softly, softly, gently, gently.

On Patrons, Benefactors and External Stakeholders

The MEU part-time project officer was finding it increasingly difficult to stay ahead of his research interests in the biomedical science department as well as the by now weekly curriculum planning meetings that were scheduled. In mid 2003 he tendered his resignation. He had already spent some months on this project before I arrived and the blistering pace I was setting I knew was probably a contributing factor. I soon found a replacement who had not only worked in the health care setting before but had recently completed an MBA which provided a useful theoretical background to understanding the change management process that was now well underway. Thankfully she shared my passion for recording and collating all documentation and was diligent at coding every single discussion paper that was generated by the group and identifying and reminding us what particular AMC standard on our project plan and timeline we had achieved. I was fixated with the project plan for I saw time slipping quietly by and many hours of discussion potentially going unaccounted for. Besides which, there began to develop a

plethora of committees external to the School, tasked with overseeing the project, whose only way of understanding our work was to regularly inspect the project plan.

Initially I enjoyed the interest in our project by external stakeholders even if interest from within the School seemed wanting. I felt that the more people were talking about the project, particularly those who occupied positions of influence from within the Department of Health, the more likely would be our success. What developed, however, was a farcical situation of more people "supervising" the work than those actually doing the work. Each of these committees (seven in total) represented several hours of work on my part simply "feeding" them with reports, updates and presentations. I invariably found myself standing at the data projector with power-point slide show at the ready and the poster of the project plan as backdrop. The clock watching committee members sat opposite scribbling important notes as I spoke from the opposite end of the table, each poised with an obscure and seemingly rehearsed question to ask at the end of the presentation, questions which alone would challenge the Minister for Health but sent my way in the first instance to allow for some repartee and always relating to imponderables like "Will you have enough staff to teach the new course?" "What remuneration had you in mind for the new staff you will need?" and "Will the new building be ready?"

I felt I would be better engaged in planning meetings with colleagues but I also recognized that SoM needed everyone's support and that included our external stakeholders. We clearly needed more hands on deck.

Securing that extra help proved difficult. No one was interested in joining our ranks, particularly as all that we could offer in return was public recognition of their contribution in the newsletter. The often cited response was "That's not my area anymore" and "How are we going to cope with the extra numbers next year let alone a new curriculum?" There were times I felt I was continually prostrating myself trying to get that elusive "buy-in". I began to imagine doors closing as I walked along the corridors of the School; eyes lowered hoping I wouldn't approach for help. I sensed the discomfort as I passed many of my former teachers. I felt I could hear their muffled irritation and imagined the internal conversation "How dare she come here with her talk

of change... She should respect and value that which she was privileged to receive... What is so wrong with the way we instruct our students anyways". I felt like shouting aloud "Is not change inevitable ...can't we work on this together?"

Then whose agenda was all this anyhow?

Time to Bring Everyone Together

The MEU Seminar Series continued conscientiously on a monthly basis. I invited guest speakers (including those from interstate and overseas) to talk about curriculum reform in medical education in other settings and for the first time another University Department (the Flexible Education Unit, later known as the Centre for Advancement in Learning and Teaching, CALT) was invited to present on the topic of case-based learning in the medical school[16]. Although attendance at these lunchtime meetings and occasional workshops remained low (mainly members of the NCWG), few could argue the content of these seminars was not highly relevant and reflected the international debate in medical education. I was using the model described in the literature of tailored staff development to support curriculum reform but attendance was very poor. Some of our guest speakers were from the US, Canada and New Zealand. Fliers and advertisements were posted all over the campus, which meant that it was impossible to claim ignorance. I occasionally received an apology from senior members of faculty after the event, saying they were sorry they had missed it. Nonetheless I felt the one benefit of this investment was that increasingly members of the NCWG were acquiring sufficient confidence to present their own work publicly and at the 2003 Annual University Teaching and Learning Conference the overwhelming number of papers contributed were by the SoM's NCWG members.

[16] A meaningful partnership developed between the MEU and the University's CALT, which resulted in collaboration over the new Graduate Certificate in Teaching and Learning.

The database of contacts in receipt of newsletters began to expand slowly. Every encounter with a colleague in either the medical school or in the hospital as I did my "rounds" resulted in an exchange of email addresses, and by mid 2003 I sensed a turning point. Attendance at our seminars and workshops began to increase slowly, although the increment was in the order of two or three extra participants. I felt now was the time to host a School-wide "get together" to discuss the plans for the new curriculum.

I penned the letter of invite to every academic in the School and to my surprise the responses just kept coming in. By the time we had 80 confirmations, the excitement and energy of the NCWG started to mount. Perhaps I had placed too much emphasis on the attendance at the monthly MEU seminar series as a litmus test for interest in the new curriculum and perhaps the continual dialogue, web postings and newsletter were now starting to pay dividends. I was determined we would do everything possible in terms of careful planning to make the day a real success. This was the NCWG's first chance as a group to "go public" and communicate our new plans since the group formed eight months ago – we would take full advantage of the opportunity this event would provide.

The venue chosen was the University Staff Club, removed from the medical school, but still on the University grounds with airy open surrounds and a location that would enable staff from all campuses to get to it easily. The title we gave to the July 2003 Forum was "Our New Curriculum: Making it Happen", impressing on everyone who attended that this new curriculum did in fact belong to us all and that it *would* happen. Once the attendees were confirmed, they were carefully divided into six compatible groups. Ensuring nothing was left to chance, a "running sheet" was prepared in advance and it allocated strict timings to each of the presenters. All of the workshop facilitators were briefed in advance so that none of this valuable face-to-face time was wasted. The workshops were interspersed throughout the day to provide a varied program and allowed sufficient time for discussion and poster viewing over the coffee/tea breaks. The final program included input from the Conservatorium of Music (I had at that stage been in dialogue about the potential for a combined medicine and music degree, an idea that unfortunately received very little subsequent support from senior executives). One of the medical students was an accomplished pianist and her pre-recorded music created the

perfect ambience over lunch. The planning even allowed for one absent member of the NCWG to deliver his pre-prepared address by video as he was scheduled to be overseas at the time of the Forum.

On the day everything went to plan.

I was particularly careful not to have the members of the NCWG chair the workshop sessions for fear the new curriculum would be seen as "belonging" to only this group. Instead, workshop sessions were chaired by key individuals whom I felt were in a position to effect change within their sphere of influence but for whatever reason had not engaged before then. Several weeks in advance of the workshop, I met with these individuals to brief them and ensure they were sufficiently familiar with documents such as the Medical Graduate Profile. They were also asked to report back to the full audience after their workshop, which would require of them careful recording of the issues raised in each of their sessions. This strategy was designed to allow a more frank airing of the very real concerns felt by the academics of this School to the new curriculum and by carefully selecting the workshop facilitators to guide the discussion we stood an even greater chance that some of these concerns might even be resolved during the course of the day.

When I look back at the photographs of the event, there was a real sense of engagement and excitement. The nine members of the NCWG who attended (we had grown in numbers since the original five) circulated around each of the workshop sessions, sat for a while and either listened to or joined in the discussion. Many of us were hearing our colleagues' concerns for the very first time. It was a bright day for July with the sun streaming in the windows of the Staff Club. Poster boards showcased timelines, project plans, models of the new curriculum, plans for assessments and even the initial findings of an intern survey we had conducted. Typically, some of the most productive discussions occurred over lunch and the various tea breaks. I was particularly pleased to see constructive dialogue occurring between various staff members who rarely had a chance to meet, such as the scientists who were based on the university campus and the clinicians who were hospital based. I felt certain that if people from all four campuses

were talking together, clinicians and scientists, rural GPs and surgeons, ethicist and anatomists, then our work was nearly done.

The report of this our first Forum was distributed to all participants several weeks later. Professionally crafted by the MEU project officer, it included a synopsis of all the workshop sessions and participant feedback. I felt we had set ourselves up as an enthusiastic, transparent, and accountable working group. This Forum and the report that followed represented for me our earliest and most significant achievement. It took several weeks to synthesize the outcomes of this event; however, the comments from participants were heartening, such as: "It was exceptionally well organized and well conducted. From my perspective I think the major outcome was that it really did get everyone engaged in talking about the new curriculum in a meaningful way" (Forum Proceedings, Medical Education Unit, July 2003, p. 3).

The University's fortnightly newsletter quoted me as saying at the time:

> The Medical Education Unit and the New Curriculum Working Group (NCWG) have worked steadily in the past 6 months to lay the foundations for a new five-year medical course to commence in 2006... The Forum brought together key medical education enthusiasts all of whom contributed to the lively debate around the proposed graduate profile and the proposed model for the New Curriculum. There is a very real sense of commitment to building a better integrated curriculum which is capable of responding to change and is based on educational best practice. (UniTas, August 2003, p.7)

The Dean's letter of congratulations a week later was further endorsement from senior executive that we were on the right track. Nine months after commencing work on this project, I felt I had finally established myself as a positive and constructive change agent and that the MEU including the NCWG, had become a credible force to be reckoned with.

Summary

By July 2003 the NCWG was in my opinion well into the second of Tuckman's (1965) five stages of group formation. Using a project management approach we had articulated the new curriculum mission, overarching objectives and model and our

communication strategy was well established. Nonetheless there were still large pockets of resistance to the planned conversion to a 5-year curriculum. Unexpected ambivalence on the part of senior members of the School executive about the need, in the first place, for such a radical reform of the curriculum, continually forced the group to question its own position throughout the first nine months and significantly hampered efforts to recruit much needed additional support. Although established in good faith, the plethora of high-level committees created in addition to the NCWG (ostensibly to keep the SoM's external stakeholders informed of all developments) served only to complicate the efforts of our small team who were still finding their way. Despite the relevance of the monthly staff development program run by the MEU these events were not well attended and it seemed to me without a "bottom up "commitment to reforming the curriculum the value of such offerings was significantly diminished. Nonetheless after nine months of perseverance the first tangible positive outcome of the project and a turning point for the NCWG was the successful curriculum Forum in July 2003, which brought most of the School's key stakeholders together for the first time to discuss face to face the new vision for the medical school. It was difficult to be certain what particular factors precipitated this turning point, although it is likely that the communication strategy (newsletters, web presence and numerous face-to-face meetings) likely contributed, for most attendees were familiar with the proposed new curriculum model and the five themes by that meeting in July. Although the NCWG had been toiling quietly on the top floor of the medical school, seemingly against a backdrop of significant resistance to change, our capacity to remain a group committed to the project despite adversity and our relentless efforts to keep our peers apprised of all of our thinking and planning appeared to be finally bearing some fruit.

Chapter 5 – Soundings from the Past I

Soundings[17] from the Past

The story is intentionally interrupted now by voices from the past. These are the voices of former Deans, dating back to the school's establishment 38 years ago. All of these men (the youngest is in his 50s) are known to me. As a former student of SoM these academics either taught me or occupied senior posts in the school whilst I was a student there. All men were engaged in attempted reform of the SoM's curriculum either at the outset when the curriculum was being planned for the first time or subsequently.

Second (and Oldest Living) Dean (1970-1982)

It is a sunny October day when I set out to meet with Professor Conroy in his home. He is the oldest living Dean of SoM and was there when the school was first established. As I approach his home where we agreed to meet, I am reminiscing about my earliest year as a medical student 23 years ago, which is when I first the almost legendary Professor Conroy. I remember his particular stance, leaning confidently and almost mockingly against the wooden lectern, thick glasses, dark suit and tie and ruddy complexion with a seemingly endless catalog of irreverent anecdotes to astound us assembled naïve First Year medical students.

The smell of cigarette smoke approaches as his wife greets me at the top of the stairs, the electric elevator along the outside stairs a sobering reminder of his infirmity. He is shuffling about in the living room waving his arms as I enter and tells me in jest how he has just been clearing out the cigarette smoke prior to my arrival. He always had a sarcastic sense of humour.

I vividly remember the formidable impression he made on me as an 18 year old student as he gleefully posed difficult questions on the physiology of fluid balance, struggling as he always did to hear our mumbled and timid responses. We always laughed at his jokes, not that he wasn't funny - he was, but you always felt on your guard. We had six

[17] Sounding is a historical nautical term for measuring depth.

years of study to endure then, if we were lucky, and it was prudent to make a good impression wherever possible.

I am a little uncertain how he will find this intrusion. Will he remember me as a student of his?

As we sip tea and he gets settled into his chair, I gather courage. I adjust the volume of my voice to overcome his hearing impairment as his wife timidly searches for documents to support his account in a back room. I am reminded of a comment from one of the previous day's interviews with a colleague of his... "remember - his bark is louder than his bite!"

"I will try and tell you the story" he begins firmly. "Do you want the story?"

A Long Way from Home

Professor Conroy arrived with his wife and family to join the first Dean of the Medical School, Professor Cyril Brown in 1964. Professor Conroy and Professor Brown were both colleagues in St Thomas' Hospital, London and had spent a lot of time discussing medical curricula:

> Just at that time medical curricula were in the air in London... There were movements... It was North Western in America and there was a new Medical School in Canada... so we used to discuss this.

The whole purpose in coming to Southern State was to start a Medical School. His colleague from St Thomas' Hospital, London had been made an offer to come to Southern State as the Foundation Dean and had asked him if he would go with him, as Foundation Professor of Physiology. He recalls it was a very bad winter in England that November and an extremely dark and foggy day when the request came through and that was part of the reason he accepted!

At the time Professor Conroy arrived in Southern State, Universities in Australia were undergoing what he described as a "shake up". Reminiscent of the current doctor shortage influencing the decision to increase medical student numbers nationally, several new medical schools were established at that time also:

> It was realised that there was going to be a shortage of medical graduates so they decided to establish new Medical Schools which they did... The arrangement for Southern State was that places would be reserved for Southern State students in New South Wales, Monash and Adelaide but they found that there was such a big demand from their own residents that they notified the University's Commission that they would no longer be able to take Southern State students so they decided to set up a Medical School here... the idea was that the school should start by taking medical students in 1965.

When he arrived in Southern State he found the new workplace posed several significant challenges:

> Neither of us had been here... and we got the shock of our lives...First of all the Hospital was woefully inadequate - you have no conception of what the Southern State Hospital [was like] ... All the staff virtually except all the junior staff were honoraries; nobody was paid, the Hospital was run by a dictatorial Hospital secretary, it was only marginally suitable as a teaching hospital.

The first catastrophe he faced was that the cost of the proposed new building exceeded the grant available (approx $1.2 million) by about $200,000. Professor Conroy recalled an urgent meeting at the time between the then Vice Chancellor, the foundation Dean and himself. His personal notes read:

> We argued initial grant inadequate for suitable bld & equipment. LM adamant no more money-scrap plans.

Professor Conroy recalls a whole series of restrictions being imposed by the local government and local University on his early plans:

> They would not sanction a Chair of Psychiatry, they would not sanction a full time Dean which all the other Medical Schools had, they would only allow one administrative officer for the School, the Clinical building would be provided with funds to provide accommodation only for pathology - medicine, surgery and administration, everything else would have to wait to be built later - it was- about 10 months later... In short they recommended that we should start in '66 but take no medical students until '67... and so on and many other restrictions.

He still recalls the pressure he brought to bear on the decision makers at the time who were arguing strongly in favour of deferment of the course until 1967 to allow completion of the building. He had taken a gamble on coming out to Australia based on his colleague and friend's recommendation. Nothing was going to plan and the resources were lean. Professor Conroy summarizes what happened next in his handwritten notes which demonstrate his energy and determination at the time:

Discussed position and agreed go for broke.
(A) Take over huts when B&Z[18] vacated in late' 65 → Life Sc Bld[19]
(B) Admit 1st yr 1965-gash 1st yr course-would dream up better one
(C) Start teaching in huts 1966 A.P.B.[20] But (a) need for renovation & repair (b) equip. So AUC had to release money (c) Huts capacity 24-24 better than nil
(D) Admission policy-common entry for 1st yr then best 24 go on
Saw VC, AUC agreed...off & running

He still feels the sense of agitation experienced at the time trying to convince his colleagues that they were in fact ready to proceed with the new medical school. He recalls a crucial meeting then held with the University hierarchy:

> There was a break in the meeting during which I dramatically threw all the plans for the pre clinical building in the waste paper basket and accused them of throwing away seven thousand pounds. Cyril Brown and I sat down and he made the point that he was going to go back [to London] in July '67 so he would have perhaps 6 months and he was definitely going back, he'd already got the Chair of Anatomy at Thomas' and out of that meeting we decided to go for broke, we would give them an ultimatum, we would start in '65.

The Earliest Vision for the Medical School

Forty one years ago Professor Conroy began planning the original medical program for Southern State. He was modest about the vision he and his colleague Professor Cyril Brown had in mind. It was better integration between the clinical and pre-clinical sciences he sought foremost. He had trialed this back in London before attempting to transplant the concept to this new medical school and had confidence in the approach:

> I don't know if it was a grand vision but we wanted to bring the pre clinical and the clinical teaching together... We had started in Thomas' which was a very conservative school. He [Cyril] ran anatomy and I ran physiology... our respective Professors were occupied with other grand things like becoming fellows of the Royal Society so we used to do a lot of the teaching... so when we did neurophysiology we did it with a neurologist- and we had patients... When we did endocrinology, we had the endocrinology people, when we did blood we had a haematologist and we taught together with them.

Professor Conroy had also been a strong advocate of small group teaching. He was in fact openly critical of didactic forms of delivery although he recognized he could only deliver what was realistic with his limited budget:

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[18] B&Z=Botany and Zoology
[19] The original huts later became the current Life Sciences Building
[20] A.P.B.=Anatomy, Physiology and Biochemistry

> I've never learnt a single thing from a lecture but we were short of staff, we were short of money... but we really wanted small group clinical bedside teaching.

Apart from the limited resources, which continued when he himself took over as Dean, he had the local medical establishment and the SoM Academic Committee to convince. Most of his colleagues had been influenced by their own, often conservative, experience of undergraduate training:

> I used to tell them they were like managing a lot of rather 'hoity toity' [haughty] ballerinas - none of whom could dance.

His recollection of his own time as Dean was a period of continually coaxing and cajoling. As Chair of the SoM Academic Committee it was a matter of continually trying to persuade his colleagues of the benefits of trying new innovations such as small group teaching:

> Well you could keep talking to them but some people are impervious to persuasion and remember that our clinical staff, medicine psychiatry and even child health and medicine were deeply imbued with traditional teaching... with the Scottish medical system which was heavily tilted towards lectures, textbooks, grinding detail and they were just not terribly interested in anything other than that, most of the time was spent arguing over allocating time for lectures which would drive me insane because I've never had any time for lectures.

In the end he often found the only way to succeed with his reforms, when dialogue failed, was to persevere and be firm:

> And a lot of finally just laying down the law.

I listened carefully to the stories he imparted almost without interruption. Everywhere there were resounding parallels. His confused commencement as Dean in 1965 marked by numerous meetings trying to convince colleagues that the decision to commence should not be delayed, resonated with my own disordered beginning in 2002, when the decision to defer the commencement of the new curriculum had likewise been taken, although in my own case, there was little I could have done to alter that resolution. He had arrived in this new post from London to find very little in the way of support and few appropriately trained staff to help in the planning and

delivery of the new program. This scenario was for me reminiscent of finding myself 38 years later amongst a small group of academics who seemed to me leaderless and without clear direction.

Had anything really changed?

He too, had a particular vision for this new medical program and saw the occasion to start a new medical school in Southern State as an opportunity to really draw upon the best ideas in the world. He had also turned to the US and Canada for inspiration. I found it quite remarkable to be listening to his personal vision for "small group teaching" dating back 40 years. I had just emerged in 2005 from nearly three years of continual planning and discussions around such teaching and learning "innovations" as if they had belonged to the last decade's thinking – and was surprised therefore to learn that similar possibilities had previously been entertained at this same school. Even more surprising was the realization that none of these original plans for "innovation" had ever been successfully implemented.

Dean (1988-1993)

Resisting Change

We meet in his rooms in Hobart, a block away from the main Research Centre at SoM where Professor Dixon spent over 15 years as its foundation director. The secretary rings him as I stand by the desk to enquire what venue might best suit him for our meeting. It is clear from the deference in her voice that although he is no longer the Director (travelling instead from his new executive post interstate to run clinics in the Southern State), he is still held in very high regard here. I find myself walking two blocks to a nearby less prestigious building. "I thought it best we meet here," he says. "It is best that way as I'm not the director any more".

Professor Dixon had come to Southern State in 1986 principally to establish a Medical Research Centre – a centre which was to go on to become the State's most successful health research institute. The concept of establishing a centre for epidemiological research in the Southern State arose from his experience in the United Kingdom. Professor Dixon had not come to Southern State with the intention of becoming the

Dean of SoM. In fact he was unaware at that time that the post was to become vacant. He was approached shortly after arriving, however, to explore his interest in accepting the post as Dean as well as his new research directorship. He was soon to learn that the School was about to enter one of the stormiest passages of its history. In the mid to late 80s it was perceived by the Australian government that the country was graduating a surplus of doctors and was looking for opportunities to reduce student numbers and possibly close some of the medical schools. The smaller medical schools, of which Southern State was the smallest at the time, were under very close scrutiny. These two activities were happening in parallel; that is, the Medical School threat of closure and the establishment of a new Research Institute. And so it was that Professor Dixon found himself as foundation Director of the Southern State Research Institute *and* Dean of the School of Medicine at the same time.

> I had only arrived in... December 1985 and had not come down intending to become Dean and was not even aware the Dean was going to retire... I was approached and approached on the basis that an accreditation visit [by the AMC] was imminent and that it was serious... and it was serious because the federal government at the time had a view that medical costs were being driven by the doctors and doctor numbers were critical and they needed to cut training numbers.

What he encountered then was a medical school struggling with its resource base and "more vulnerable" compared with other Australian Medical schools:

> They [other medical schools] were more successful in terms of the money they had. They not only had money from the Universities, they had money from the state governments for clinical positions, their clinical positions were intertwined... In a way that didn't exist here and they had much better health and medical research money so their total presence was much greater.

Professor Dixon spent many hours in budget and planning meetings with the State Department of Health trying to convince the State of the need to spend more on undergraduate medical education. He recalls the frustration he experienced when he calculated the overall expenditure by the State on training of doctors and compared this with other similar sized institutions:

> I do recall putting in a paper for budget & planning... about our internal dollars for the students... and comparing the total spend on students with what was available through those other two medical schools and it was a good deal more in Newcastle... Particularly the state government contribution there was vastly greater than here - here it was just a few hundred thousand dollars... whereas it

> was in the millions there... So we recognized when we did this that we had a very poor basic funding for a medical school because it [money] wasn't coming from other sources... so we were looking for other ways to get more money, more critical mass for our teaching dollars without adding more teaching - extra teaching that would eat up people's time.

As a consequence Professor Dixon and his executive team made some strategic decisions to improve the School's pecuniary interests:

> We made a firm decision to take on full fee-paying students and that at the time was even a little controversial... It was happening...but we hadn't been doing it to such an extent... We were looking at ways of increasing our income, our income and our critical mass of people that we would employ... We also looked at increasing research income because we were well below the lowest.

Despite these efforts, Professor Dixon still found himself continually defending the School against criticism for its poor financial state. He particularly resented this criticism being expressed by stakeholders whom he felt ought to have had the School's interests at heart, such as colleagues from the State Department of Health:

> When I went to speak to some of the individuals concerned they pointed out to me that the Medical School is costing something like let's say six million dollars a year and they would like to save that money and I said to them well you know that money is coming from the federal government to Southern State it's not your money... They weren't so aware of what was going on... They didn't have an affinity for academic affairs and they didn't have a strong feeling for the Medical School... it was reflected in the money they gave.

When he commenced he also encountered staff who were perceived by the AMC as rejecting curriculum reform:

> Well I think the problem was that the faculty was not able for whatever reason to show the momentum in change that the accreditation committee [AMC] would have expected and I think that was for a few reasons. It was probably the inward view of the Faculty at that time... they thought what they were doing was fine; they – at least subtly – resisted change... Certainly not wholeheartedly getting behind it...and also just the lack of resources.

Yet the threat of the medical school being closed during that time was real. Professor Dixon was of the view that should the School receive a poor result at the forthcoming accreditation visit, the government may have acted upon that information by recommending the closure of the State's only medical school:

> It was quite a definite view supported by the senior bureaucracy in health in Canberra and a view the Minister of Health held... a bad accreditation committee report could have been acted on by government.

Professor Dixon found amongst his staff little enthusiasm for the specific educational changes being recommended by the AMC at the time such as better integration of clinical and pre-clinical teaching and problem-based learning:

> Within the School of Medicine yes there was *not* a lot of enthusiasm and quite a lot of opposition particularly from senior Faculty, and their argument was we're training medical graduates who are as good as any so why should we change and this new way of looking at things is not likely to be helpful... I could see the great difficulty we would have changing with a staff that was not going to change very quickly because of their stage in their career or lack of money.

Even amongst his senior committee he found institutionalized resistance to curriculum reform:

> At that time... the Dean was elected and we had a professorial committee where the 10 professors sat around once a month, had a meeting, and voted on issues and made decisions so they were very influential and in the main not very interested in the change.

Hence he felt the most significant contribution he had made during his time as Dean was to avert the potential disaster of the School's closure. According to him, were it not for the carefully considered response by the School to the external accreditation committee in 1991, the school may well have been closed:

> I'm pleased the Medical School wasn't closed, I think that was a serious possibility and I think by going about the response in an ordered way where the things we suggested were clear – and some of them not only achievable but achieved - did have an impact on that accreditation committee... So to put a stop on that was the most important achievement and really that was what I went in for.

Although he sat opposite me appearing confident and relaxed, he recounted the events frankly and his candor was somewhat unnerving. I came away from the meeting feeling privileged to have heard an unrehearsed and honest account of the real challenges he faced in the late '80s, during which time I had been a medical student at SoM. Listening to his story I could imagine the strain

he had endured attempting to initiate reform in the school over 20 years ago, juggling as he did his many responsibilities. Implausible though it seemed, he found it impossible to convince colleagues in this medical school (that he had been invited to join), which was clearly under threat, of the desperate need for reform. He knew the resistance he encountered threatened the long-term viability of the School but no-one shared his concern or his vision. I recollected my own sense of both incredulity and isolation at the commencement of the recent curriculum project. I could not understand why a landmark project such as this which had resulted in my full time appointment and the establishment of a new unit should be so ignored and disregarded. I also recall the feeling of disbelief as doors along the school corridors started to close as I walked by for fear I would ask for assistance. Professor Dixon had also encountered, as Professor Conroy before, surprising resistance from senior faculty in the school who ought to have known the vulnerable position they placed the school in by *not* adopting change. I was reminded of Bloom's (1973) metaphor of the "giant amoeba", when he argued that medical schools tend to "absorb" the effects of new ideas and change in ways that in fact seek to preserve their traditional structures and functions. I came away from that meeting with a sense of his disappointment, for a Medical School that under his reign might have enjoyed the same success as the neighbouring world renowned Research Institute did under his subsequent leadership.

Dean (1994-1996)

A Different Take on the Ideal Medical Graduate

Professor Adams received a call one lunch time from the Vice Chancellor, which was to significantly change the course of his career. The call was to ask him to accept the then-unpopular appointment as Dean which had been vacant for some time. A series of recent interviews for a replacement had failed to identify a suitable candidate to take over leadership of the Medical School:

> I said no I wouldn't be prepared to do it, I really don't think I have the qualifications or anything and he said well I will give you 2 weeks to think about it and I went away and thought about it and I really thought it was far beyond me but... About 10 days into the 14 I suddenly thought well there are a lot of things that I'd like to do and like to see changed and if the Vice Chancellor will give me adequate support to even do it and we have to do it within three years to get accreditation and so I rang him up... I said the real situation is that if I take

> it on and I don't achieve it people can say I was arrogant, and if I take it on and do achieve it people can say you were brilliant!! He was a guy with a great sense of humour, he laughed heartily at that, but this [my] appointment was very unpopular.

Professor Adams clearly recalls the events during his difficult time as Dean. He took a different view from that of his colleagues and saw the criticism being leveled at the School by the AMC at the time as a "wake up" call:

> I think that that attitude was typical of the attitude that was there, that it couldn't be changed and it wouldn't be changed and it shouldn't be changed and part of that was because everything is wonderful, we are turning out great graduates and so on... Part of it was because of these territorial disputes and partly because there wasn't a lot of vision.

Despite the disillusionment and bitterness he endured as Dean (which I later learned included a vote of no confidence from colleagues communicated to the media) he always maintained a sense of humor. As a medical student I recall his smiling mockery in examinations and on the obstetrics and gynecology wards. This was his distinctive trait.

When we meet in his rooms in a busy specialist Hospital in Sydney, he is just emerging from several hours in theatre during the night operating on a lady with a gynecological cancer, who developed unfortunate and unexpected serious complications. After an eager sip on his coffee he begins to define what makes a "good doctor" and what it was he wanted to achieve 12 years ago as Dean of SoM. He uses this morning's clinical case to illustrate the particular point that the capacity for reflection needed to be included on the long list of qualities he saw as required:

> This lady I've got in intensive care at the moment I've got to go back in my mind and think what have I done right or wrong here and I've got to be able to be honest enough to know... what I've done wrong because some people run around flagellating themselves for things they couldn't control and other people totally deny any wrongdoing... you know so anyway that's where I thought the curriculum should go.

He expressed other attributes which were not likely to appear on a conventional list, such as the need for a sense of humor, and recalls having to welcome first year medical students during his time as Dean:

> I had to speak to each year's intake of first year students when I was sub dean and... I sat there and I listened to [other colleagues]... speak of pious stuff like 'you have to work so hard because it's a really tough course' and so on - and I knew that was [nonsense]... These are true things but they're a bit nauseating...I

> read in a newsletter that comes around from some educational thing that said the 3 things you should get from a liberal education are humanity, humility and humour - and I feel that those are characteristics that medical practitioners really need.

I move about my seat uncomfortably as Professor Adams leaves nothing unsaid about his troubled time as Dean. He had endured personal criticism and loss of friendship during his tenure and yet had shown great courage by accepting the post at such a difficult time in the School's history. Despite this adversity he has emerged with his own sense of humor intact and still motivated to ask the enduring question "What makes for a good doctor'? I would have enjoyed his company around our recent planning table as we ourselves debated the attributes of the ideal medical graduate. None of us had mentioned a sense of humour. Perhaps this should also to be considered a necessary attribute for the curriculum reformist too.

Summary

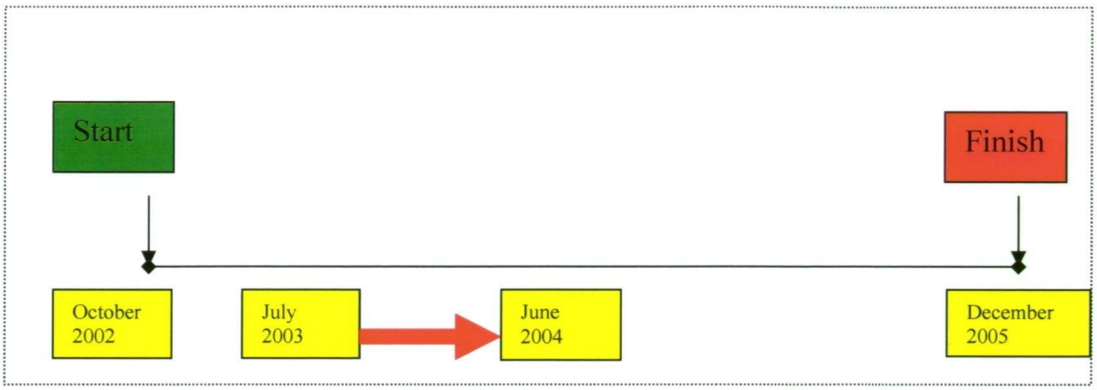
I listen carefully to all the Dean's stories. Everywhere there are strong parallels – confused beginnings, laudable visions for change, difficulty convincing colleagues, limited resources and managing resistance to change. A common thread in all the conversations was a sense of disappointment that the School's full potential had never been realized. As they impart their own past experience of change I am reminded that many of the reforms we now regard as new and progressive, such as small group teaching or problem-based learning, were not new innovations after all. There had been previous earnest attempts going back nearly 40 years to introduce them here at SoM. I begin to see our contribution as perhaps not so unique and distinctive. Perhaps Simon was right when he compared the vision and outcomes of our new curriculum with most others he had encountered, describing them as "looking very similar" to other medical schools. I took issue with this in my own mind at the time for I felt we had invested heavily in defining the vision for the new curriculum and were genuinely committed to producing a distinctive program for our future students. Now I realize others have

travelled a similar path. I also begin to reflect on one of the first pieces of advice I was sent in my new post, which I also took issue with at the time but which now begins to take on new meaning:

> *It might be worthwhile considering why there has been little progress in curriculum development to date, given the AMC have been giving us the same message since 1991*

Why had so little progress been made since 1991? More particularly why had such little progress been made from the very beginning? Was it all simply explained by "resistance to change"? Was I expecting too much from my own team and our efforts now? Had I set the goal posts too high? How would I measure our success? And finally how would I emerge from this with my sense of humour intact?

Chapter 6 – Growing Pains



Fuelled by the success of the first school-wide Forum on the new curriculum, the momentum of the NCWG increased in the second half of 2003. This was timely as between July 2003 and June 2004 SoM was expected to submit two significant documents to the AMC in the form of a Preliminary and a Stage 1 submission, articulating developed plans for the new curriculum. Only after favorable endorsement of these plans by the AMC would SoM be permitted by the Council to continue the work of developing a new curriculum. These deadlines saw a significant volume of discussion papers generated by the NCWG which continued to meet fortnightly. The workload increased steadily. Two of the clinicians in the group resigned during this period, owing to mounting pressures and competing clinical workload. The State was also experiencing a widespread shortage of doctors. The increasing numbers of medical students enrolled in 2004 was creating an extraordinary challenge for teaching staff. In June 2004 the Dean announced a formal independent review of the School's teaching resources. Meanwhile the three clinical schools united to form a state-wide committee to contend with the challenges they each now faced.

The Paper Trail

Several months after the first curriculum Forum, the newsletter of the Southern State branch of the Australian Medical Association (AMA)[21], ran a short story about the School's curriculum planning progress:

> The New Curriculum Working Group and the Medical Education Unit are to be congratulated on the clarity of their communication about the most substantial curriculum undertaken in the history of the [School]. (*TasTalk*, 2003, p. 19)

Endorsements such as this from stakeholders outside the School provided much needed encouragement for us (the NCWG) to move confidently forward to the next deadline, which in this case was our first written submission to the AMC (referred to as the Preliminary Report) due in September 2003. This time frame was very tight and would just about allow us to capture the collective ideas which had been consolidated at the Forum and added to since. New ideas kept emerging from the group though, and there was so much still to be done. Although we had considered the vision, the outcomes and the model,we had not yet looked in detail at other critical matters such as modes of delivery, assessment, student selection criteria and evaluation.

I felt strongly that the Preliminary submission to the AMC should aim to say something, however insignificant, against each of the standards articulated in the AMC guidelines[22]. This would demonstrate our wholehearted commitment to the AMC accreditation process, which I felt was important given our previous track record. In addition, I felt by using the standards as a framework for each of our submissions we would ensure a systematic way to monitor our own progress against each individual standard over the next two years, as well as educating staff in the school about the standards. Some of the other members of the NCWG were not so convinced, feeling that this would place enormous pressure on the group by asking us to comment on aspects that we had not yet sufficiently debated at that time. I persisted for I felt we had lost considerable time in the first year of the project establishing ourselves as a credible planning group against

[21] The AMA is the main national professional association of Doctors in Australia.
[22] http://www.amc.org.au/images/Medschool/StandardsPart2-2007.pdf

considerable resistance. Now the tide was slowly turning in our favour and we had to run fast to stay ahead. I was thankful the AMC had recommended deferral until 2006 after all. I recommended that as a strategy, instead of all of us considering each standard together, we "carve up" the work that needed to be completed amongst the then eight members of the NCWG. Given the expertise and special interests of the different members of the NCWG, we grouped ourselves around the relevant AMC standards and several "task groups" emerged under the aegis of the NCWG; one relating to assessment, another to student-related matters such as admission, selection and support; another to coordinate planning around curriculum content and case writing, supported by a themes task group and a fifth to focus on evaluation. The list of acronyms grew. The Assessment task group, the ATG, was particularly significant given the key place reform of assessment practice would play in changing the face of the new curriculum. The Curriculum Content task group (CCTG) became the remit of a clinician and scientist pair from the NCWG to ensure balanced input from these two important "camps". The Themes task group (TTG) represented the group of newly appointed theme coordinators who had agreed to champion the five themes, working closely with the CCTG. I elected to coordinate the Evaluation task group (ETG) as curriculum evaluation sat comfortably within the remit of the MEU.

I felt now was the time for the NCWG to move "outside the walls" of the 4th floor office and seriously engage our colleagues. As a planning group, we had been working in relative isolation for close to 9 months. This situation had evolved as we had needed to establish ourselves as a group and develop plans sufficiently which we could then take to our colleagues for comment. It was not for want on my part of requesting extra help through senior management. Staff in the school seemed content that "someone" was planning the new curriculum which freed their time to focus on more immediate concerns. Nine months into the project I felt if we did not actively seek to engage with our colleagues across all campuses of the school, then the curriculum would be seen as belonging to the NCWG – a small group of elite academics who sat for hours talking and debating in the executive suite of the medical school and not belonging to the broader community of teachers at SoM. The first Forum had taught me that silence from our colleagues did not necessarily mean disinterest, although we were still planning in

an adverse environment. There were other explanations for our colleagues' lack of participation in the planning process, such as preoccupation with more immediate concerns like increasing student numbers and increasingly stretched resources. I saw it as our brief to do whatever was necessary to find a way for others to make a contribution, however small, and to acknowledge this contribution for example through our newsletter. I also felt that unless we did this our group was at risk of "groupthink" and developing the "illusion of unanimity" (Cline, 1990). I felt we had started to become almost too comfortable as a group of now nine. We still just fitted around my office desk and it was almost as if there was room for no more. The struggle we experienced outside this office was cementing our relationship as a group. Yet despite many of our colleagues' private opposition to the new curriculum, the inescapable fact was that 80 people had attended and participated enthusiastically in the recent Forum and now was the best time to capture that energy. We agreed that we would each separately seek to co-opt whomever we could, to assist us on these "task groups". The plan was to minimize the "burden" we imposed on others, accepting whatever help they felt they could provide. Hand written notes on pieces of paper and conversations in the corridor were all considered legitimate contributions.

The administrative support for these task groups was to be provided by the MEU and progress reporting would continue through the fortnightly NCWG meetings.

When it came to articulating the terms of reference for the Content task group, a fundamental issue emerged for the pair whose task it was to lead that activity and that was: "Whose responsibility would it be to include or exclude curriculum content and who would be the final arbiter?" There ensued significant disquiet about the task that lay ahead. Although by now it seemed clear to me that this was the NCWG responsibility alone, some members of the NCWG were still hoping to be rescued by more senior academics in the school who hitherto had remained disengaged from the curriculum planning process.

I could not help feeling that some of the NCWG members' attempts to recruit were disingenuous in an effort to keep the group at a manageable size. It is easier to make

decisions when you have fewer people to consult. As Chair I knew this to be true; however, for a curriculum to really work it needs to be owned. Nonetheless, try as we all did, additional assistance was not forthcoming. Our efforts to form these additional task groups from within the NCWG had become, it seemed to me, a futile exercise in simply dividing the efforts of an already small and under-resourced group. The one possible exception to this was the Themes task group, which represented an addition to our ranks. These recently appointed champions of our five themes were co-opted, with the support of the MEC and the Dean on the promise (from me) that any extra work would be kept to an absolute minimum and that all the "paperwork" would be undertaken by MEU administrative staff (I now had three part-time project officers). The theme coordinators were hand picked by myself in consultation with the Dean. Over time each of these coordinators attended the NCWG meetings, representing not only a swelling of our ranks but also a constant and encouraging reminder to me that we were adhering to the "outcomes-based" model of curriculum design.

Growing Clinical Pressures

The pressures of clinical work and the tyranny of distance contributed to our first academic staff resignation. Our only rural medical specialist was forced to step down and with her I felt we had lost a critical link to the recently established rural clinical school in the north-west of the State, where she was based. I had known for some time this resignation was imminent. All the usual tell tale signs were there such as the last minute cancelled teleconferences owing to unavoidable delays in her clinics and the frustration in her voice as she tried desperately to catch up on decisions we had made during our lengthy NCWG meetings. I felt this first resignation deeply, although others followed over the three years of the project. This particular specialist had made an outstanding contribution. When she was able to attend the meetings in person she did so, which meant a four-hour drive to the main campus. More commonly she linked in to the meetings by teleconference for up to an hour at a time. When she finally conceded it was proving all too difficult to maintain a steadily growing rural palliative care practice single handedly and contribute to the development of the new curriculum, I reminded her of the outstanding contribution she had made in helping articulate the professional aspects of our "medical graduate profile". She had been particularly keen that we

articulate a clear vision for students which encompassed professional aspects of practice such as team work skills, leadership, self-directed learning and self care. I gave her my sincere assurance that a place would always be reserved around the planning table should she find the time to return.

Trying to maintain a core group of active clinicians on the NCWG was always going to pose a major challenge, as the demand for clinical services outstripped the State Department of Health's capacity to deliver medical care. We were developing a medical curriculum at the worst possible time, in the middle of an acute doctor shortage, and I knew we would have to invent creative ways to secure input from and engagement with our clinical colleagues without overburdening them.

The Growing "Wish List" of Learning Outcomes

The minutes from our NCWG meeting in August 2003 describe how we sought to resolve the issue over who would take ultimate responsibility for the content of the new curriculum. The debate had become less about what to include (we all had firm ideas about this) but more now about what to exclude, as "space" in the curriculum was becoming difficult to find. I felt we ought to make these decisions ourselves; others were not so confident about our remit and authority. I was beginning to see that some of the group were finding their ideas easy to articulate in the office where we met each fortnight, but much more difficult to explain in the tea rooms of their own departments.

I tried to be sympathetic as I knew everyone on the NCWG was under enormous pressure particularly from senior colleagues (some of whom were direct supervisors of NCWG members) who rejected plans such as those which would see contact hours reduced to 20 hours per week to allow for more self-directed learning time, particularly if the reduction in hours directly impacted on their department. The 4th floor office was becoming a clearing house for ideas only and I had hoped by now we would start making tangible plans that had identified resources and staff ownership.

I myself experienced numerous fleeting "corridor consultations" with hospital colleagues who expressed firm opinions about what the new curriculum should contain.

Most expressed their deeply felt concern about the reduction in years of training from six to five and wondered how it was possible to train quality medical graduates in this time. On many occasions I began my rehearsed response, which spoke of the need for a more integrated learning experience, and the place of self-directed and life-long learning, but I rarely had the opportunity to finish these conversations before hospital pagers bleeped to intervene or the glazed-over expression announced my colleagues' complete loss of interest. What was even more difficult at this time was seeking common agreement from identified "content experts". Even from within the same department or indeed specialist colleges[23] we often encountered contradiction. Finally, with more suggestions for inclusion than available time and space in the curriculum, we decided that the most appropriate approach was for the NCWG to define (through a process of consultation with available and willing colleagues) the learning objectives sought by the *end* of each year of the five year program. We would leave it to the unit coordinators (yet to be appointed) to define the detailed learning objectives for each individual unit of study as long as each unit of study (four per year were proposed) achieved the end of year objectives. Whilst this circumvented the real issue of insufficient engagement from our colleagues, it partly addressed the question of who would take responsibility for what was not to be included in the new curriculum. Although this was in my opinion a less than satisfactory outcome it was nonetheless a resolution which allowed us to keep moving forward and maintain much needed momentum in the project.

The NCWG, with its now dozen members (the Theme Coordinators had boosted our number) from a variety of different disciplines both clinical and non-clinical, continued to meet fortnightly for up to three hours in the now cramped surroundings of the "MEU office" around a single desk with barely enough room for papers and coffee cups. I suggested it was more efficient to circulate discussion papers in advance of our meetings to save valuable time and most of us adhered to that. Nonetheless our most productive discussions occurred spontaneously. I found the excitement and hum which emanated

[23] Postgraduate medical training is coordinated by specialist colleges such as the College of Surgeons or the College of Physicians. Each recognized specialty has a dedicated College which oversees standards and training.

from the group when we were constructively focused on creating new ideas and identifying solutions the most gratifying moments in those three years.

My personal vision for this time was to have a complete repository of learning objectives in a searchable database, making transparent to staff and students the content of the curriculum and providing a vehicle for curriculum updating and renewal. I had seen and read of examples of these in other medical schools which had been the work of usually part-time instructional designers, and those I had seen seemed to trivialize the curriculum, not enhance it. What I had envisaged was a tool that would be accessible to and used by *all* teaching staff in the medical school, whether they were anatomists in the dissection room, clinicians teaching students at the bedside or general practitioners teaching students in the community. No-one, it seemed, had the "complete picture" of the medical curriculum. Most understood their own particular contribution and maybe the contribution of others in their departments but few had a full picture of what was taught where and how across all years of the course without reading a voluminous set of written documents. I wanted to change this, particularly as we had the opportunity to capture every detail of this developing new course.

Our attention to record keeping did "pay off" though, and a comprehensive "Preliminary Submission" was dispatched to the AMC in September 2003. It was, in some respects, an ambitious undertaking for our first submission, as I made certain every standard contained in the AMC manual was addressed in part or whole in that document. I hoped it demonstrated how serious the School was about genuine cooperation with the process and that we had embarked upon significant reform with a thought-out process to achieve this, led by the NCWG and supported by the MEU.

The Expanding Paper Curriculum

Phillipa needed little convincing of the virtues of a well-documented clearly articulated curriculum. She had joined the NCWG as the Theme 2 Champion and had 20 years'

experience with the old curriculum, watching it grow in a haphazard fashion - never fully understanding when and where certain aspects of the curriculum were taught:

> The new curriculum is in a sense a much more systematic and documented approach to building a curriculum, delivering the curriculum and assessing that curriculum, whereas the existing teaching in the clinical years - up to this date - has been very much more about the sort of "master-apprentice" style of teaching and in that sense its been very variable, its not been strictly measured or monitored.

She described the modern day medical student as wanting to know well in advance what the learning objectives of each unit of study were. With all students now paying HECS[24] fees and many working part-time to assist with payment of these fees she felt that students now "had a right" to know the details in advance about what content was going to be covered in each unit and how this would be assessed:

> They want to know what depth they need to go into things - I think the world's changed. We've got students who are asking for very clearly defined parameters...much more demanding clientele than we've ever had I think.

With the new curriculum evolving as a much more carefully documented entity, Phillipa saw this as a distinct advantage to staff and students, although she recognized that it could be seen to compromise some of the previous autonomy staff had – something which she nonetheless felt needed to occur for the greater good:

> But it's a sacrifice by individuals for, if you like, the greater good of the whole curriculum as it hangs together - as one entity.

Simon, however, did not agree. He felt the obsession with recording objectives and the accumulation of curriculum documentation that seemed to proliferate over the course of the project was a distraction. Simon had more experience than most of us on other medical school accreditation committees throughout Australia and had seen many different versions of what he referred to as the "curriculum on paper". He felt we had spent too much time discussing specific learning objectives and that the existing traditional curriculum had provided a lot of material which we could already use in the new with minor adaptation:

> I think my view from the very beginning was that we could produce a curriculum on paper because after all there's dozens- everybody's done it, if all

[24] HECS: Higher Education Contribution Scheme

> else fails you steal bits of other people's... In the end after much arguing around we've ended up a bit where I thought we would which was adapting a good deal of what we've got in the current curriculum.

It was heartening for me to talk with Phillipa. As one of our newest members I felt she could provide the group with a fresh perspective. She was also bringing a different viewpoint as she hailed from the psychology discipline. I also valued her evaluation of how she felt the group was performing. As someone with 20 years' experience with the old curriculum which she felt was neither transparent nor accessible, it was heartening to receive endorsement that she found the new curriculum documentation easy to navigate and the process we were using transparent.

Simon's opinion, by contrast, I found less palatable. Although undoubtedly the process of painstaking record keeping and listing objectives and outcomes was tedious, I did not regard this as a mere "paper exercise". I felt this description demeaned the many hundreds of hours we had all (including Simon) spent in careful and considered consultation. The medical graduate profile, although in its final iteration admittedly looked much like any other medical school's list of competencies, it was nonetheless conscientiously crafted from first principles – it was, I felt, "home grown ". I also felt we were serious about "constructively aligning" (Biggs 2003, p. 26).The only way to do this was to have well-defined, and clearly recorded objectives for each unit of study. Assessment should be directly linked to these objectives, not random unpredictable events unrelated to the content of the curriculum, which had sometimes been my experience as a medical student. The ideal was a centrally coordinated, carefully recorded, curriculum. To do this, however, required the ultimate sacrifice by all teaching staff – their hitherto completely unquestioned autonomy in the classroom, to deliver what they wanted, when they wanted, and how they wanted.

The Pace Quickens

I was heartened by the Preliminary submission's favourable endorsement by the AMC. Admittedly it would have been unusual, but not improbable, that the AMC would have

disallowed the project to continue to the next stage on the strength of such an early submission; nonetheless I was personally quite proud of the achievement. This was the first tangible evidence of the group's efforts. I wished the others would see it that way but by the time the response came back to the School, the NCWG had become embroiled in a debate that was to divide the group and remained unresolved for a considerable time. As a group we could not agree on whether the focus should remain on the "big picture" and continue to describe end of year outcomes for the final two years (by now we already had a clear vision for the content of the first three years) or whether to now "drill down" and start preparing detailed plans for the first year. My view was that, after 11 months deliberating, we had spent sufficient time on the overarching vision and structure of the new curriculum (with little apparent success engaging staff), perhaps more focus now on the detail would allow other academics to see more clearly how the curriculum would unfold and provide a more meaningful entry point for their input. I felt it was time to bring together the NCWG, including the recently appointed theme coordinators and those who would translate our ideas in the first unit of study, and start to put some "flesh on the bones". I managed to convince the majority of the membership and a crucial workshop was planned for early November 2003. This time, however, I would *not* lead the planning and coordination of that event. I felt it was time to delegate if the notion of rationing the workload amongst the task groups of the NCWG was to prevail. It was particularly difficult for me to relinquish direct control and allow others to set the course for this event for I was particularly anxious we did not lose the support of potential first year module coordinators and teaching staff[25] for the sake of poor planning. I had a particularly rigid planning regime which had served me well in the previous forums and workshops I had organized which left nothing to chance and included considerations such as who would be best suited to the different workshop groups. I was anxious not to lose any of our hard-earned credibility with colleagues, particularly in the wake of a successful first submission to the AMC, and wondered whether I ought to keep my hand more firmly on the steering wheel. Nonetheless, I remained faithful to my promise and played a background role in this event, my only

[25] Module coordinators were those responsible for the delivery and assessment of each unit. Although they had not yet been formally appointed for the new curriculum it was possible to predict who the likely candidates for the first year would be.

contribution having been to recommend the bright airy and tranquil environs of the local Botanical Gardens as the venue.

I was pleasantly surprised. Overall it was a very successful endeavour and many of the staff who were likely to be teaching the first year of the new curriculum participated enthusiastically. The dilemmas the first year teaching staff posed related directly to their own proposed contribution which again to my surprise, they had all considered. There were many aspects the NCWG had *not* taken into account. I felt we had gained some additional partners during that workshop who were prepared to gently point out some deficiencies in our plans, particularly those who saw their place in the new curriculum as inevitable, as it became clear to them that they were being given the opportunity to help shape the new curriculum which would directly affect them in two years' time. In the December 2003 edition of *Catalyst,* the CCTG proudly reported that:

> The first pass of the [first unit of study] has been completed and will be circulated for review and comment in the early part of the new-year... All involved have found the process challenging, but rewarding as the new curriculum is finally taking shape before our eyes.

Despite our setbacks, the project was finally beginning to take on a life of its own. We had met constructively for the first time with colleagues who had quietly read our many discussion papers. They could now see where their part would "fit in" and were accepting of this. There was also a sense that if any one of the members of the NCWG, myself included, stepped away from the process the others could – and would – carry on. Despite the pressure I sometimes felt and how vulnerable the project sometimes seemed, I was beginning to feel that we were all, every one of us, potentially dispensable.

Trying Hard to Remain Faithful

Not all my efforts to delegate, however, yielded such success. Some of the task groups, I felt, were interpreting their terms of reference more literally than I had hoped. A continual tension for me was the need to interpret and translate the ideas of the group as pragmatically as possible when reporting our plans to the MEC and in time to the AMC, without diminishing the group's vision and enthusiasm. When one of the task groups

insisted on a complete overhaul of the School's selection and entry process, a decision I knew to rest not only with the School but the University executive, and one which I knew would have little, if any, internal support, my only recourse was to instigate a meeting with the Head of School to allow the matter to be resolved quickly. It was for me a difficult dilemma. Was I forsaking the group's vision for the new curriculum by not encouraging a serious review of the selection and entry procedures for the school? For instance, if communication skills were to be an integral part of the new course, then selecting students who were strong in this area would be advantageous, but what of international students for whom English was not a first language? There were many elements to this debate which drew us reluctantly into the political sphere. I felt we needed to choose our battles carefully and this one was not worth the fight. The debate over selection and entry requirements for the new curriculum continued in an open forum for a short while. I put my support behind the relevant task group by inviting a national speaker who had made sweeping changes to selection and entry in his own medical school to speak to the School executive and the NCWG. Nonetheless as I had predicted the matter was finally put to rest by the School's executive, who recommended in favour of the status quo. For the first time I felt the benefits of the "arm's length" authority and it was reassuring for once *not* to have the final say. Despite my efforts to support constructive dialogue and although nothing was ever said I was left with the feeling I had lost the respect of one of the idealists in the NCWG over this important issue and wondering whether perhaps we had capitulated too quickly on this important matter.

Singing from the Same Hymn Sheet

No sooner was the Preliminary Report dispatched than I focused the group's efforts on the Stage 1 submission due in the middle of 2004. Keeping everyone united and focused was a proving a major challenge. Four distinct sites of curriculum activity had now emerged around us and at times it was overwhelming trying to ensure we shared a common vision. The NCWG was clearly focused on developing the first three years of the new curriculum to commence in 2006; however, the three clinical schools were otherwise occupied reforming the last two years of the existing program with the introduction of more case-based teaching as well as continuing to manage the steadily

increasing student numbers. I was anxious that the last two years of the program would graft well onto the first three years we were planning and it was important that the overarching medical graduate profile was the underlying document informing all of our reforms. However, the lines of communication with the other clinical schools were not as easy to manage. Distance was a significant factor, and so too was the tension that existed between all of the groups working on curriculum reform, as each group was keen to maintain autonomy, and yet maintaining (through the NCWG) a centrally coordinated focus for the new curriculum was my paramount concern. I could only ever be reasonably confident about the day to day workings of the NCWG, as we met frequently, but staying ahead of developments across the State was an entirely different matter. During this period I spent increasing time traveling between the three sites, or on the phone, armed with the medical graduate profile of the new curriculum, trying to facilitate dialogue between the three clinical schools as well as the NCWG. I often wondered if it was in fact my place to keep everyone "singing from the same hymn sheet". Each of the schools was trying to express its own unique identity and I slowly began to realize that the NCWG did not have the monopoly on championing curriculum reform.

A Clinical School is Reborn

Mary is a specialist in her late 40s, who divides her time between complex and demanding clinical responsibilities, a newly acquired executive role and her teenage family. She has recently taken over as the new Director of the Northern Clinical School, having been urged and encouraged to apply for the post by her colleagues at Northern.

We meet in her recently refurbished office spaces, for which she and her colleagues had been campaigning for many years. She is keen to show me around. There is no natural light in the teaching space as the building she occupies is in the basement of the main Hospital. Next door to her are located the Hospital's Engineering and Asset Management spaces. A couple of final year medical students are writing up case studies on the available computers next door, and other students are chatting in the nearby tea

room. She insisted this space be created for students as close as possible to the hospital and preferably on the hospital site so as to facilitate the movement of students from the teaching wards to a dedicated quiet teaching and learning space. She and her colleagues wanted this space to be regarded by students as a form of "refuge" from the chaos of the hospital wards two floors above. It was the students' own space for self-directed learning and was designed with soon-to-be graduates in mind.

As I enter her office, coffee in hand, refreshed from my two and a half hour journey, Mary apologizes as she is still dictating a letter over her secretary's shoulder. As we sit down she finds space for our coffee cups amidst a proliferation of student portfolios she has been marking all morning. Not surprisingly Mary's new office also doubles up as an extra tutorial room. Evidently, planning had not taken the expanding numbers of medical students on clinical rotation into account.

Mary's recent promotion to directorship of the Medical School's second largest clinical school was something of a baptism of fire. Although she had taught medical students for "as long as she could recall", the decision to accept a leadership position in this clinical school she attributed to the enormous encouragement and support she had received from her colleagues. The retirement of the previous director created a vacancy and an opportunity she and her colleagues seized upon. It was the opportunity to take full responsibility for the continuance of the medical program in her locality, or risk having it run from the main campus in the south. The appointment coincided with the change in the executive positions at the local Hospital which she claims helped enormously:

> I guess I fell into it because I'd largely just been a teacher as part of my VMO (Visiting Medical Officer) responsibilities and I've always enjoyed it and I guess it was formalized more because of in our area - there was a crisis... in terms of the way the whole of the... program was being delivered in 5th and 6th year and I guess the people were very keen in this place that it actually continued and they were very keen in a sense to have a real go at it, do it well - and if it survived then that would be good, if it didn't then that would send messages to all the right sorts of people... So with a lot of support from friends we set about trying to revitalise the program here in the North.

She was always looking for new ways to invent herself and add interesting dimensions to her work, all the time maintaining a solid clinical focus. Pondering the implications of having recently accepted the directorship position she says:

> So that's the motivation I mean the other thing is I've always, like most of the people that I've been involved with, I've enjoyed teaching. I like also the fact that the curriculum development gives you a chance to diversify your own professional life... There's no doubt that bright young things keep you on your toes and you know I just like the change. I really enjoy the chance to do the graduate certificate as it sort of keeps you going a bit... You're a long time dead... If it hadn't been this it would have probably been something else... I think the challenge of it is enjoyable.

Mary had recently enrolled in the "Graduate Certificate"- to improve her theoretical knowledge of pedagogy and was now feeling more equipped to fully immerse herself in the world of medical education. She had views on the qualities of the "good teacher" which she recently had the opportunity to share with other teachers from a variety of disciplines on the Graduate Certificate program. She firmly believed that whilst effective teachers can be taught to improve their skill as teachers, good teachers are born:

> I always thought along the way that the best teachers are those teachers that succeed in practice. I mean if the market decides that they're a success... it usually means that their colleagues think they're okay... I think if I was to look for somebody who was a really good teacher I'd probably think about what their colleagues thought of them and that usually means that they can enjoy people, they can sort of see the wood for the trees, they can think creatively around situations, they can think outside of situations... They can see what is doable and... what can be done isn't always what needs to be done - those sorts of things.

What she loves most about teaching senior medical students is the challenge and how it keeps her knowledge current and "sharp":

> It keeps you on your toes... I mean if you ever had to be involved with a group of students who have the capacity to be really extraordinary I mean medical students are, they can be both precious and difficult and arrogant and naive and they can be amazing and achieving and all sorts of things, most of them have got the intelligence... That's not usually an issue... I've loved seeing the lights turn on.

Reflecting on the "master-apprentice" style of teaching she had enjoyed as a medical student she recalls how it was the influence of significant mentors that made the greatest impression:

> One of the really good things I think that I've had is I had a fantastic grounding as a medical student myself... It was very progressive...There were the social sort of justice issues I think that very nicely tied in together and I just happened to be extremely fortunate in rubbing up against... some really amazing teachers and the thing that struck me about them is that I don't think that they ever considered themselves as being teachers, they were practitioners... They taught

> by doing doctoring and doing what they did well... I went through with Dr Philpot who was a wonderful man and... when I think back I think about his patients that you learnt from, I can actually see the patients and the way he involved you in dealing with them and how he actually made you think about what was important for that particular person... so I had some really good role models.

This personal experience helped shape the teaching philosophy she fosters amongst her own team of clinical teachers, whom she has carefully selected for their clinical expertise as well as their capacity to inspire the students.

An underlying tension for staff in the Northern Clinical School for some time, however, was the perception that resources had been unfairly concentrated by the University hierarchy in the South, at the main campus. Mary and her team were determined to turn this around, hence their determined battle recently for extra teaching space. Their motto from the outset was "We'll show them". They had resolved to make a success of their clinical school and that the students would experience something "unique" when they came on rotation to Northern. Behind the bold façade, however, was the belief that the Medical School must be placed ahead of all politics:

> I mean there's no doubt absolutely underneath all of this is that if the Medical School goes to the wall the profession will go to the wall in this State and University politics... aside... it's the one underpinning belief... the sustainability of the School... It's School survival.

The decision to take on the task of reinvigorating the Northern Clinical School was one she remembers making as a group. She recalls meeting socially one night with her colleagues who were physicians, general practitioners, surgeons and anaesthetists, plotting a future for the School that entailed all of them working together as a cohesive unified team:

> When I say "we" I actually think of about six or seven people and there's one night when we sat with a couple of bottles of red wine... We were really concerned about where medicine was going in the Northern region...and we realised that the health of the hospital system was absolutely critically dependent on the Medical School being viable, functioning and effective... We'd give it a really good nudge and if... we couldn't get anywhere we would say 'oh well, it's not our fault' and we were sort of significantly neurotic and high achieving enough to realise that we would give it a good nudge.

She is very proud of her team's achievements to date, describing each of their individual talents:

> [The] people that we've got around us each have I think their own particular strengths that complement each other. I'm a fairly dogged sort of worker but I'm not a process person but I can sometimes have ideas and get things done... whereas Anne, my colleague, is a process person absolutely focused, can work things out beautifully and that's good because I'm some things that she's not, she's definitely things I'm not... then within our immediate extended sort of group there are... the "showmen" and there are the quiet sort of solid people - so it's a small but I think relatively balanced group.

Much like the NCWG, they too had given serious consideration to the qualities of the ideal graduate. Although she admitted this had not been documented as thoroughly as the NCWG had done in the form of the Medical Graduate Profile, about which she made a passing reference, nonetheless the knowledge skills and attitudes required of a final year medical student was a recurring topic of discussion and debate at their meetings.

She and her colleagues saw it as their job to help prioritize for the students all of their previous learning and impart to them that information which was "really important". For Mary and her team, this was more than just the basic rudiments of history taking and examination; this was the ability to recognize the real cause of the patient's presentation to the clinic or the really sick child. What she also really hoped her students would take away with them was the ability to enjoy people:

> I'd love them to be able to as I say it "pick the punter". I would like them to be able to come away with the ability to enjoy people from a professional point of view... I mean if you don't enjoy the different shades of people I think you'd find it very hard to be a sustained doctor in whatever pathway you went... The narrative of medicine, if you like, is one of the things that you take away with you as you get older... It's not so much the disease but the people that have had them... The narrative of medicine is a really pleasurable thing to be part of and a privilege to be part of - the rest carries itself.

We talk a little about the new curriculum developments happening "down south". Mary relies on her newly appointed Medical Education Officer, who is a member of the NCWG, to keep her posted on the latest NCWG developments, but for now her main interest is to get Northern School curriculum in good shape. After all, it will be some years before the new curriculum cohort of students arrive on her doorstep. She speaks metaphorically of the two sets of plans eventually "dovetailing" – her plans in the North and the NCWG's plans in the south.

> I guess we've sort of in a sense worked backwards - whereas if you think about the new curriculum you might be building up - we've worked backwards from what we see a doctor going out into first year practice should have their minds around.

Mary spoke passionately of a curriculum for the final two years which was distinctive and unique and of an undergraduate learning experience which could not be matched anywhere else in the State. There were however few references to the activity of the NCWG in the South and I could not help wondering whether her Medical Education Officer (who was a member of the NCWG) was in fact faithfully reporting all developments to her and her staff as had been agreed.

After we parted and I had time to reflect. I realized Mary was as enthusiastic about her own area of influence (namely the curriculum in the last two years of the existing program) as we were about the new curriculum. Admittedly both programs would merge at some time in the future and would need therefore to link up and share agreed outcomes and assessment strategies but I could expect no more from her at this time than passing acknowledgement of the work of the NCWG. Mary is fully engaged with her own set of challenges: establishing a clinical school with its renewed vision, growing student numbers and a limited number of staff. I took comfort from the knowing that her vision of the ideal medical graduate was in no way at odds with the NCWG vision. The fine details we could develop over time.

The Growing Need for Staff Development

Throughout 2003 and 2004, the staff development program continued in the background, using every opportunity to showcase and discuss plans for the new curriculum and engage a wider group of academics. I was convinced of the need for continued "faculty development" and targeted aspects such as the underlying theory of adult learning, case-based learning and curriculum evaluation. Unless teaching staff of the medical school understood the background and rationale for the changes we were proposing, genuine curriculum reform would be impossible. The average participation at these monthly events had reached a steady state at about a dozen, half of whom were members of the

NCWG. Nonetheless we persisted each month with advertisements posted on all the available poster boards, stairwells and the lifts of the medical school.

I had identified a small number of academics in the School across the three campuses who were interested in acquiring a theoretical basis for teaching in higher education and so I involved myself with the University's plans for a new Graduate Certificate in Learning and Teaching. By becoming a member of the design group for the program I was able to ensure the program was developed with the needs of medical educators in mind. In addition, it was agreed that if enrolments were from the health-related schools I would participate in the delivery.

The staff development program was a constant reminder to me about what would become MEU "core business" once the curriculum reform and planning phase was complete. The series of monthly seminars I organized kept the MEU and NCWG activities evidence based and focused on best practice. Over the following 12 months the guest speakers and workshops included national and international experts in medical education who provided much needed inspiration for proposed changes in the new program. The NCWG had gained valuable first-hand experience with curriculum reform and I felt it important that we gained confidence in ourselves and our vision by regularly engaging with other medical educationalists with whom we could now share our own experience. These educational gatherings became the glue that kept our small group of dedicated medical educationalists united, particularly when myriad factors threatened to undermine our efforts and drive us apart.

More Reports and More Resignations

The tedium of report writing continued unabated through 2003 and early 2004. The AMC now required an annual report on the existing curriculum to ensure the School was not abrogating its responsibilities here, whilst plans for the new curriculum were clearly gaining momentum. I decided to undertake a series of strategic evaluations which would not only satisfy the AMC[26] but also inform our developing curriculum. As resources were limited I focused on just those elements of the current curriculum that were likely

[26] AMC Standard 7 requires documented evidence of *Program Evaluation*

to transfer over to the new program. The School had been strategic in introducing "case-based learning" into the last two years of the existing six-year program anticipating the "grafting" of these years onto the new program (i.e. the last two years of the existing six-year program, with the modifications to incorporate more case based teaching, were to become the last two years of the new five year program).

The focus of the particular evaluations I had planned therefore was around this new approach to delivery, "case-based learning". I wanted to investigate how both staff and students rated this new approach to delivery. The results of these evaluations provided much needed information to support our planning for the case-based activities scheduled for the first year of the new curriculum in 2006 and beyond. In particular, feedback from the students about group size and group tasks, as well as the conduct of the sessions, was both helpful and insightful.

The year 2003 ended, as it had begun, with more positive endorsements from the Dean communicated in the December edition of *TasTalk,* which read:

> For the Southern State School of Medicine, 2003 was a year of considerable activity and achievement, both of which can be expected to continue in 2004...significant challenges facing the School have been tackled with increased vigour and resolve by staff, students and other stakeholders. (*TasTalk*, December 2003, p. 13)

The article went on to articulate specific achievements which included the "well attended" staff development activities and workshops run by the MEU and the Preliminary report commended by the AMC. The article also forecasted some of the challenges that lay in waiting for 2004 which included the increased domestic student numbers (increasing from 62 to 83) and a major review of the School's resources to be jointly funded by the Department of Health and Human Services and the University.

My first job in 2004 was to announce another clinical resignation from the NCWG, this time not to clinical work but to research. The chair of the Assessment task group was not only a critical responsibility within the NCWG, but also someone who would be difficult to replace. The portfolio was complex and the workload significant. As a group, we

argued more forcefully about assessment than any other agenda item. Once again I found myself in conversation with the departing clinician reiterating the offer to keep a seat around the planning table for him. As this was our second resigning clinician, I began to worry whether we would lose credibility with the medical profession who might see the curriculum planning process as losing relevance and direction with so few clinical champions on the NCWG (as I myself had taken a temporary break from clinical duties, despite 14 years' clinical practice, I was not regarded as having the same clinical focus compared with colleagues who were still engaged in full-time clinical practice). I put these concerns aside and as I had considerable experience in assessment of clinical competence particularly in the postgraduate setting, put myself forward as the temporary chair of the AWG until a replacement could be found. I was reluctant to do so for fear, as chair of the NCWG, I would lose sight of the "big picture", in addition to which I already had responsibility for the Evaluation Working Group; however I could see no alternative. I hoped that a suitable replacement would emerge as had been the case with the first resignation, but it was some months later before we finally made the decision to subsume this task group under the NCWG. Although this represented another major overhaul to our process, it had the advantage that student assessment was considered by every task group of the NCWG and became an integral part of all of our planning.

Agenda for Action

Despite the significant set back this resignation posed, the agenda for the first NCWG meeting of 2004 was full to overflowing. Attachments to the agenda included a timeline for the AMC Stage 1 submission, an Excel spreadsheet containing 170 "sub-outcomes"[27] listed under the five themes and arranged according to potential timing of delivery across the five years; a listing of the proposed weekly cases to be used in the first year of the new program with the corresponding rationale for their inclusion in each module; and a comprehensive assessment strategy, a legacy of the outgoing chair of the Assessment task group. I sensed the group becoming more resilient as we embarked on the now familiar task of preparing to document once again our plans to the AMC. Without prompting the senior project officer had produced a work-plan for completion

[27] A term we coined to encompass statements of learning intent which sat above unit learning objectives.

of each section of the next submission with actions for each member of the NCWG arranged under the relevant standards.

Following the appointment of the new Director of the Northern Clinical School, I was keen to forge even stronger links with this site although it would be some five years before the impact of the new curriculum would be felt there. The MEU newsletter *Catalyst* ran a short story each month on statewide developments and our fortnightly NCWG meetings always included a representative, linked by phone, from *both* the northern and northwestern clinical schools. I also ambitiously tried to maintain links with the postgraduate training programs in the State, inviting key representatives to participate in our meetings as well as our staff development sessions but these relationships, though well intentioned, proved bilaterally difficult to sustain.

In March 2004 I was invited to join the accreditation team of a neighbouring much larger medical school. This was not only a welcome reprieve from the tedium of meetings and report writing, but an opportunity to participate and observe first hand the operation of an AMC accreditation visit to which we would be subjected in over a year. I gained a great many insights on that week-long visit.

I returned to Southern State convinced of the direction we had taken with our own planning and confident we could succeed, despite our more modest resources. I had made some important breakthroughs by participating in that accreditation visit which would stand us in good stead when it came to our own week-long visit in May 2005, such as the need for confident and succinct delivery of presentations by the NCWG members addressing each of the AMC standards as well as the need for a focused and concise written submission. I had also become convinced that as a school we should look for the opportunity to run a "trial" or mock accreditation visit before May 2005. When I began to share these ideas with the group, it was quickly pointed out to me that the total number of people on our NCWG was equivalent to one of the interstate school's smaller task groups. I decided to file away the insights I had gained for future reference. This was not the time to become embroiled in yet another convoluted discussion about resources.

Growing Concerns about Resources

Within two months of returning from the interstate accreditation visit, I was pleased to be able to discuss the tentative appointment of our first two unit coordinators who agreed to join the NCWG. These appointments required careful negotiation on my part as both were adamant that their duties were quite specifically to support the development of, *not* the delivery of, the first two units of the new curriculum. Neither was prepared to make a long-term commitment to the new curriculum this far in advance. Both members of staff also insisted on the need for immediate backfilling to free them of some of their existing teaching responsibilities. The request seemed reasonable but a drawn-out debate ensued over the need for a revision of existing staff profiles and workloads in their department before either was able to give a firm undertaking. I found myself entangled in several months of complicated discussions about performance management and equivalent fractions for the sake of an extra day per week of dedicated curriculum development time.

Apart from staffing issues and increasing student numbers, the other issue that loomed large for the medical school at this time was the need for additional space. Despite the allocation of $12 million to the State from the Federal government for the redevelopment of the medical school, there remained widespread concern about whether the School could accommodate the increasing student numbers in the interim. I could no longer single handedly contain the growing concern from the membership of the NCWG about resources and robust discussions were finally entered into between the NCWG and the School executive about staffing the new curriculum. Some of the group saw the forthcoming AMC submission as the opportune time to declare these concerns in writing. The April 2004 minutes record a discussion about the forthcoming AMC report and the need for it to be "frank and honest" in regard to the [School's] lack of resources pointing out that such an open admission "might stand us in good stead as the AMC may be able to petition support from our local government on the School's behalf". I was adamant that this was not the approach to adopt for I felt, given my recent interstate accreditation experience, that our submission to the AMC was no place for political lobbying or a discussion about resource deficits and that, in this regard, the School alone

(and not the accrediting body) was responsible for creating its own destiny. Increasing our student numbers, despite the short term pain this created, was in fact part of the solution.

Growth in Student Numbers

Not everyone saw the increased student numbers as a burden. Some, like the current Dean, saw it as an opportunity for the School to build its much needed resource base. We sit opposite each other in August 2005 in his office, around the table with the heavy carved chairs where he meets members of his executive on invitation only. Quietly spoken, reserved and unassuming, one would hardly think Professor Phillips sits as the second longest serving Dean of this Medical School. He had arrived in the School in 1987 around the time of the school's first accreditation visit, which as he described "had posed a whole lot of problems" for the school. Between 1987 and 2005 he had participated in a number of the School's medical education committees and had recognized the need for change and so the decision he had bravely taken as Dean in 2002 to proceed with developing a new integrated 5-year curriculum was the culmination of many years' deliberating over curriculum matters.

Professor Phillips had always recognized that just maintaining the existing number of 40 or 50 domestic students was not a viable option for the future of the medical school. He had seen the impact of the Federal government's clamping down on medical student numbers in the 90s when he and many other medical school Deans decided to supplement domestic student numbers with international students. He had been grateful for the additional student numbers allocated to his school over the years, however small, such as the ten overseas trained medical graduates (OTDs) who enrolled in the last few years of medicine in the late 90s and a few years later the extra ten medical rural bonded scholarships - ten of the total 100 allocated nation wide.

It was not until 2004 that the 83 domestic student numbers put the school into what Professor Philips described as a *"viable ballpark"*. Having achieved that goal, the next challenge posed to the school was to identify suitable clinical placements:

> We knew at that stage we had to expand our clinical places, we were never going to cope with just our traditional programs at the [local teaching hospital] with a little bit of a rotation to the North and then a sub rotation from there to the North-West. At that stage the University Departments of Rural Health were starting up... so they were able to support students in rural environments and so we envisaged with the rural clinical school we'd be able to have three cohorts of students who would by and large spend their last two years in one of those settings.

As Dean, he recognized the extra strain this would place on his staff but was confident he had negotiated a figure with University administration that would enable the school to remain financially viable:

> I think having got the extra numbers was essential. It produces its extra stress but I'm pleased we got those numbers. If we tried to go for them now I don't think we'd get them - and so at the time when [the Department of Health and Ageing] rang up and said can you take twenty-one extras - I didn't think too long about it... I've always had the view that we could probably manage about 100 students in the clinical placements in each of the last 2 years. It wasn't entirely a guess because we had had in the past a group of say 60 students in 5th year...so I thought that if we aimed we could expand those community placements plus the private sector - we could probably manage 80 in the north. With a quarter of the population in the North-West plus additional funding for a rural clinical school I thought we could probably take a quarter of a cohort there... So I think that the battle I've had with central administration recently is that, that number is maximal - we are going to struggle to get there over the next few years...but I think it's doable.

It was, at the end of the day, a "judgment call". There were no magic formulae for determining capacity and his assessment was that his staff could and would manage the numbers of students he proposed admitting to the school.

Minimizing the Pain and Maximizing the Gain

It was not just all about student numbers either. Professor Phillips had been particularly keen to ensure the impact of the new curriculum reforms on staff was kept to a minimum and that students of both curricula, the existing curriculum and the proposed new curriculum, felt equally catered for. He saw the proposal to modify the last two years of the current program (by introducing case based learning) and then grafting these two years on to the new curriculum as a way of minimizing the impact on staff who were then not faced with rolling out a new program each year for five consecutive years:

> I suppose the other thing that I realized at that stage was that a transition from six to five years was going to be a fairly difficult and painful exercise... I wanted to try and limit the degree to which we had duplicated teaching and so we I guess evolved the idea that we could really reform the last two years with a view to collapsing with the new course coming through and I think that, also... overcame one of the problems that I kept seeing in reviews of other Medical Schools where there were these 'change-overs' and the students in the old cohort very much felt like a lost tribe... I don't know how that thought arose - I think it's been quite a useful thing for us...at least, we are minimizing the impact of change. In a sense, it's still occurring and it still has an impact but its balancing it a bit more with the overall program and for the students and hopefully the staff.

Although he admitted he did not recall where the idea came from, the developmental process benefited students and also the School in its use of resources. Students in the final cohorts of the "old" course benefited from the reform changes in the last two years whilst those in the new program would benefit by progressing into an already established and evaluated final two years of an otherwise new program.

As Director of the Northern Clinical School, Mary was well placed to comment on the impact of these student numbers. Her challenge was to find adequate clinical placements for her growing number of 5th and 6th year students. Although she fully accepted that eventually the increasing student numbers would provide overall benefit by redressing the national and global doctor shortage, she saw the quality of training in the interim as being potentially compromised. Apart from her own close-knit team of clinical teachers, many of the hospital-based specialists who also taught medical students were increasingly preoccupied with service delivery. She often encountered cancelled scheduled ward based teaching of the 5th and 6th year students as a consequence. The burden of teaching the students then often fell to senior registrars,[28] themselves preparing for specialist examinations. She also troubled over whether these young trainee consultants, whom she referred to as the "middle tier", were fully prepared to provide this critical teaching role. Mary wanted these 5th and 6th year medical students and the trainee consultants to eventually return to the North to provide clinical care and knew this would only occur if they had enjoyed a satisfactory

[28] Consultants in training

and supported learning experience there themselves. This in turn would only happen if she was able to invest in their immediate education needs:

> I actually believe the critical issue in determining the success of the last two years of the program is one of the numbers and clinical placements, and... importantly is that middle tier of postgraduate education, ensuring that that middle tier of postgraduate education can train the initial clinical placements so for example like having 5th and 6th years out in places or even in the wards with pre-internship programs very much depends on a training registrar being on site.

It seemed that for those of us working closely on the development of the new curriculum, we all wanted the best possible outcome – a vibrant new medical curriculum which embraced world's best practice in medical education, a sufficient number of dedicated and supported medical teachers and a sufficient number of medical students to make the medical school viable. But arriving at that point would take time. Everyone seemed to expect the increased student numbers would immediately generate income for the school which would in turn facilitate extra staff appointments. This was not occurring in a timely fashion at all and staff morale was consequently being eroded, which continued to hamper our efforts to recruit support and engage staff in the planning process. It seemed to me the new curriculum had become associated with additional hardship: extra students, more tutorials, more space requirements but no increase in resources. I had hoped by now for a very different response to the project.

A new curriculum but at what price?

A Significant Milestone is Reached

The Stage 1 submission was a formidable document when completed, consisting of over 120 pages not including 25 large appendices. The MEU staff who had spent many unpaid hours collating, printing and binding the report celebrated the occasion with a cake upon which were iced the words "Bon Voyage Stage 1 submission"! With this submission I had the first real sense that we were making very good progress on our journey. All we had to do now was wait for the response from the AMC due a month later – a response which would provide feedback on our planning thus far and hopefully invite us to continue the planning towards a new five-year curriculum.

Becoming an Academic Unit

Although these submissions to the AMC prepared by my unit represented many hundreds of hours of planning and deliberations, I rarely heard them referred to by anyone outside the NCWG. Whilst other academics and departments were engaged in either teaching or research (and in some cases both), the MEU had become preoccupied with the less academic (and therefore I felt less valued) tasks such as the preparation of lengthy reports on the School's behalf. Having dispatched the second of our major submissions to the AMC I now felt it time to engage the MEU in more academic pursuits.

I decided to subject the current curriculum to some form of validated evaluation that would allow benchmarking with other medical schools. The proposal to introduce a shorter, more integrated medical course provided the impetus, I felt, to examine objectively the real strengths and weaknesses of the existing 6-year medical curriculum and to collect data which would allow comparison not only with other medical schools but also with the new program in the future. I also invited students of the final two years of the program to complete surveys and participate in a number of focus groups designed to seek feedback from the student body about the case based learning.

National debate at the time was advocating the need for more robust evidence-based approaches to evaluating medical curricula (Australian Doctors Fund (a), 2005), although best practice in evaluating the appropriateness and effectiveness of medical curricula was then (and is still) evolving. I came across a study which looked at recent Australian medical graduate perceptions about how prepared they were for hospital-based practice using a questionnaire designed and validated in Australia. I felt that interns (doctors in their first postgraduate year) would be well placed to comment on the perceived effectiveness of their undergraduate training and as most of our graduates took up internship posts in the State, tracking them down would be relatively straightforward. Insights from recent graduates were a robust way to start to collect data about curriculum outcomes, particularly as we were reforming the "old" curriculum and in

time would have graduates from the new curriculum to compare with. I seized upon the opportunity and sought permission to use this survey in our medical school (Hill, Rolfe, Pearson et al., 1998). The survey revealed some interesting results which we eventually published (Mac Carrick, Winzenberg, Holloway et al., 2005; MacCarrick, Bradford, Vial et al., 2007). Foremost amongst our findings was that the existing 6 year medical curriculum had a particular strength, when compared with other Australian medical programs, in the teaching of the scientific basis of medicine (which we had already decided was a strength we wanted to continue in the new program). Importantly we also identified a weakness in a number of other areas such as communication skills, which we were seeking to redress in the new curriculum. For the first time we had tangible evidence to support the introduction of our reforms and further support for the proposed five theme areas we had independently developed.

I was pleased with this modest research contribution given the other competing demands on our time. I felt this publication would help further establish our credibility in a medical school which valued research and scholarly activity. I had been trying to convince colleagues of the rationale for change and this paper demonstrated this need, using an evidence-based approach, as well as highlighting our commitment to changing only those elements that required change, whilst retaining the strengths of the current program. It was all a matter of not "losing the baby with the bathwater", I argued.

The Review of Resources is Announced

The June 2004 edition of *TasTalk* announced the commencement of the much needed review of resources jointly funded by the University and the Department of Health. The entire process was to take ten weeks to complete. Up until this time the NCWG planning had occurred in a resource "vacuum". No one had been able to provide clear direction about the proposed new curriculum budget or the required human resources recruitment strategy. It was clear to everyone on the NCWG we would need extra staff to deliver the amount of small group teaching we had proposed. In ten weeks we would finally know the answers to these important questions and so I felt it was worth the effort to cooperate fully with the consultants who came with a background in university financial systems and medical school operations. I did not realise then how much extra work this

consultation process would create for me and for the team. Although the initial meetings occurred in ten weeks the whole process took several months to complete and our own curriculum planning was continually interrupted by requests for estimates of numbers of teaching hours and space required to deliver the new curriculum. When it was complete I felt we had in fact conducted the expensive consultant analysis ourselves. What occurred however was a more detailed level of planning than we had anticipated this far in advance. We were careful not to make too many concessions either and no matter how many times we were asked by the accountant on the consultancy team, the "magic number" of ten students per small group or case based discussion group was not exceeded.

Another Forum to Bring Everyone Together

By June 2004 we had an activity timeline that spanned the final 18 months and we were prepared for the next annual Forum which was entitled "The New Curriculum – In Focus" - a title chosen to signal that we had moved on from the "making it happen" theme of the event 12 months previous. This Forum was once again carefully planned. Each task group was asked to succinctly summarize key developments in ten minute time slots, allowing sufficient time for questions and debate. The program was full to capacity and the walls of the venue we used (the University staff club) dotted with posters bearing the MEU banner. I invited a harpist to provide background music during the "break out" sessions to facilitate a tranquil ambience; however, her music was barely audible over the din.

This forum was to be the final opportunity for staff from around the State to meet face to face before the final submission to the AMC and it was reassuring that over 60 participants attended from different campuses of the medical school. What was even more surprising was the interest from the local media. Two television stations responded to the media release, arriving unexpectedly during our lunch break with cameras and crewmen. Not only was the media interested in the new curriculum, but the broad representation by the local medical profession was also very heartening. What I hoped was that all of this interest would translate into more "hands on deck" when we returned to the planning table.

The Clinical Schools Unite

One of the major outcomes of the June 2004 Forum was the agreement to establish a State-wide Clinical Schools Working Group (SWCSWG) in response to the evaluations my unit had conducted with students and staff from all three campuses. These evaluations, which included the results of focus groups conducted around the state, highlighted an alarming lack of consistency in assessment practices across the three clinical schools. The purpose of the SWCSWG, therefore, was to bring together the three heads of the three clinical schools (with their respective education staff) at regular meetings to agree on curriculum content and assessment for the last two years of the current curriculum. I was invited to join this group, which meant that the NCWG plans would also be communicated on a regular basis and inform planning.

When the SWCSWG met for the first time a month later, it was reassuring to hear a number of references to the new curriculum's medical graduate profile and to eventually see this document incorporated into the unit descriptions for fifth and sixth year. The addition of the new Director of the Northern Clinical School (who was enthusiastically embracing change) was, I felt, now having a positive influence on curriculum reform and the climate of change in the three clinical schools. She was now wielding more influence than I could ever bring to bear from my southern based office. I felt a sense of relief not having to continually drive the change agenda in the North and the Northwest when my more immediate concern was getting things prepared in the South for the first three years of the new curriculum.

By the second half of 2004 the new University Graduate Certificate in Learning and Teaching was well underway and over one quarter of the enrolled staff were from the School of Medicine, and most of these from the NCWG or the SWCSWG. This was an astonishing statistic, which reaffirmed my commitment to staff development and prompted me to later develop with colleagues from the School of Medicine a dedicated Graduate Certificate course tailored specifically for educators teaching in the health

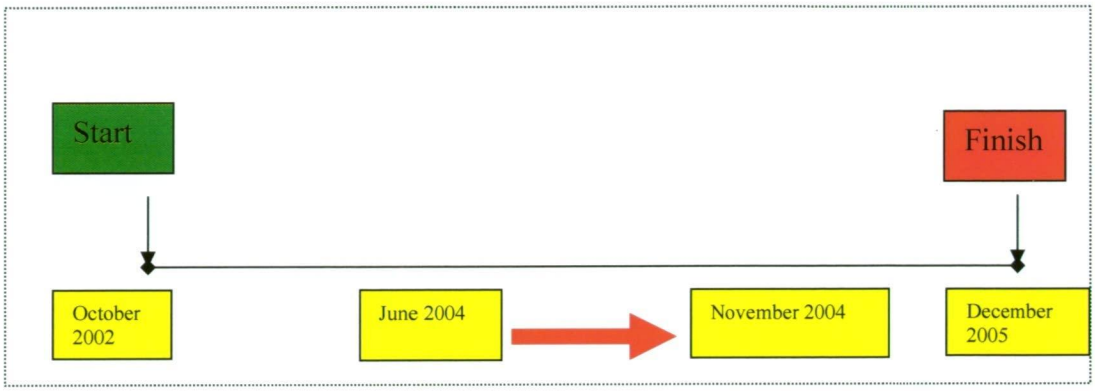
professional programs.[29]. There was now a real sense of growth of interest in the medical education area at SoM which was driving the NCWG making us and the process stronger and more confident each day. I no longer felt I needed to shout so loudly to be heard.

Summary

By June 2004 the Preliminary and Stage 1 submissions to the AMC had been dispatched, articulating developed plans for the new curriculum. Several setbacks were experienced between July 2003 and June 2004 in the form of two resignations but despite these the overall membership of the NCWG expanded during that 12 month period. Despite the fact that one of the resignations was the chair of the Assessment task group, most of the targets set out in the project plan were realized. The increasing numbers of medical students enrolled in 2004 created an extraordinary challenge for teaching staff around the State and their discontent only seemed to abate when a comprehensive review of the staff and space requirements of the new curriculum was finally commissioned. Although this review created extra work for the NCWG, we were by then sufficiently advanced in our plans for the new curriculum to provide this consultancy the details of the first three years of the new program. By the second Forum in June 2004, many of the NCWG were enrolled in post-graduate courses in medical education and spoke confidently about the underlying educational theoretical basis for the new curriculum. Our NCWG meetings continued unfailingly each fortnight with a demanding and busy agenda.

[29] http://www.utas.edu.au/tl/prof-dev/graduate-certificates.html

Chapter 7 – Under Siege



This chapter traces the period June 2004 until November 2004. During this time the work of preparing the content for the final submission to the AMC was undertaken. The group gradually expanded in size bringing on board "unit coordinators" who would help translate the "vision" for the new curriculum and propose timetables for the first two years of the new course. As the group size expanded, some of the original members of the NCWG considered the vision for the new curriculum had become "diluted" and that the cohesiveness of the group was being eroded. There was continual discussion and debate regarding the School's capacity to resource the new curriculum. These issues eventually resulted in further significant loss as two more members stepped down from the NCWG. Throughout this time the affiliated main teaching hospital was embroiled in a political battle, with some of its doctors threatening to withdraw services and withdraw their support for the medical school. I felt the new curriculum development process was under siege from within and from without.

Setting the Stage for the Final Submission

The Stage 1 Submission received an encouraging endorsement from the AMC and I felt July 2004 was a time to celebrate our achievements thus far. In his letter to the MEU and the NCWG, the Head of School pointed out that the AMC did not usually make comments like "impressive change" in their correspondence back to Medical Schools and that we should regard this type of commentary as significant:

> I would like to extend my congratulations to you and the Medical Education Unit and particularly the New Curriculum Working Group on the very successful outcome of the Stage 1 Submission to the Australian Medical Council. The Committee's response to both the Stage 1 Submission and the Annual Report should be a source of satisfaction to you and your team...congratulations on an excellent outcome.
>
> *(Memorandum from Dean dated 21st July, 2004)*

Feeling buoyant and motivated, I wasted no time drafting another work plan and timeline for the preparation of the second and final Stage 2 Submission, due a short six months away. This next submission needed to be a more focused application with clear evidence that we had the capacity – physical and human resources – to deliver the proposed plans. Yet it was the sustainability of our capacity that troubled me most. Was the School capable of resourcing in the long term the plans we had laboured over for almost two years, which included extensive use of small group teaching?

The newly appointed unit coordinators, one of whom had been teaching in the first year of the curriculum for over a decade and was rumored to soon be retiring, contributed regular written reports articulating how *they* were interpreting the delivery of the new curriculum "on the ground". These two academics had become a critical part of our planning process now, for they were helping the visionaries amongst us consider curriculum implementation on a more practical level. This was important dialogue given the next AMC submission required a more detailed account of our planning. Although we had agreed in advance that these unit coordinators would *not* be responsible for the delivery of the first two units of the new curriculum, only the planning, I nonetheless hoped they would reconsider once they began to see plans taking shape. I took heart from the fact that discussions at our fortnightly meetings between the five Theme Coordinators and the unit coordinators as well as the other members of the NCWG were increasingly taking into consideration what was feasible and practical. Everyone seemed to me at this stage prepared to compromise to help realize our plans.

As this process got underway, I could see benefit in creating a physical "space" for the new curriculum at the Sandy Cove campus where the first year would likely be delivered. I felt the new curriculum was at risk of being identified with the MEU office and not seen as "belonging" to the whole of the medical school. As the two unit

coordinators were located 5 km away at the Sandy Cove campus, it made sense to suggest that we explore better support for their role closer to their location. The promise of a $12 million Federal Government grant for a "state of the art" medical school building, in which both the Sandy Cove campus and the city campus of the medical school would be collocated, still sat on the planning table waiting additional funding before it could proceed. It looked more likely than not that we would be commencing the new curriculum in the old medical school buildings on the Sandy Cove campus – the same buildings in which I had started my own medical training 22 years ago. I decided therefore to relocate one of the part-time project officers there to assist the new unit coordinators, creating the first hub of medical education activity away from the MEU office. It was a risk as I had so few staff and could little afford to divide the team's efforts, however the more compelling factors now were the need to support this important activity of "putting flesh on the bones" of the first year of the new curriculum and the need to be more visible in the location where the first year of the new curriculum would be enacted.

Unfair Criticism

The Sandy Cove idea worked well – to a point. My visits there soon confirmed the benefit of having relocated support to that site. The MEU project officer steadily developed an effective working relationship not only with the unit coordinators, but some other staff as well. Nonetheless, we still had a long way to go to gain the confidence of many of the staff at Sandy Cove upon whom the burden of delivery for the first two years of the new curriculum would rest. I listened to the many different concerns expressed directly to me or conveyed through my project officer. Not only were staff there confronted with the prospect of delivering a new curriculum, they were also the first to be affected by the increase in student numbers. In addition, the proposed medical school rebuild would see many of the staff from Sandy Cove relocated to the city centre, which they argued would compromise important geographic links with other science-based researchers. Finally the issue of staff shortages loomed large as a number of key staff from this campus were rumored to be announcing their retirement plans to coincide with implementation of the new curriculum and no discussion was forthcoming about staff replacements.

Having now three staff members of the curriculum planning team (about a quarter of the total NCWG membership) located at Sandy Cove I was confident we still had sufficient time to "convert" what I saw then as the "late majority" and "laggards"(Rogers, 1995). The opinion of some members of the School's executive based in the city centre was less sympathetic. I frequently became embroiled in discussion with senior staff, many of whom I felt had themselves avoided engagement with the curriculum reform process, condemning the Sandy Cove academics claiming they were "exaggerating their workloads" and had their "heads in the sand" when it came to the new curriculum. It was not my place, however, to compel engagement with the curriculum reform process. All I could hope for was an understanding from staff that was similar to my own, that things would indeed change, for the better, and a recognition that if they embraced the reforms in advance then this was clearly more sensible than leaving it all to the last minute. As time went by, particularly as I spent more time at Sandy Cove, I found myself empathizing with staff who remained ambivalent about the virtues of the new programme, anxious about the long-term effects of the additional student numbers they were already experiencing, angry about the lack of resources to manage the expanding student numbers and legitimately concerned about the lack of space (there were stories of medical students sitting in the aisles of the single large lecture theatre).

Squeezing the Curriculum in

Our two coordinators continued to translate the vision and slowly they began to reach their colleagues in Sandy Cove in a way the rest of the NCWG failed to do. As the newest members of the NCWG, they quickly picked up the terminology and were soon conversant with the many acronyms that had by now become second nature to the rest of the group. As we started to construct timetables for the first year, it became apparent that some of our proposed content had been overly ambitious. I felt we needed to trim everything back, but was uncertain how best to proceed. The school's only resident anatomist pointed out that 40 hours of dissection was the absolute minimum time he required to deliver to students the schedule we had envisaged. We had planned on much less time. I had no reason to doubt his recommendation as he was one of the few staff from Sandy Cove who was at this time "on-side". He had made the considerable effort to identify innovative ways to incorporate anatomy, aligning it for the first time ever

with the proposed weekly clinical cases. The question then became how to ensure the other content areas in Theme 1 (such as Biochemistry, Physiology, Microbiology and Histology) were included as well as making sufficient room in the timetable for the other four themes. In addition to managing the concerns raised by members of the NCWG, I now felt the added responsibility of trying to accommodate the increasing number of justifiable claims by content experts who were slowly contributing to the discussion. The "late majority" were making their presence felt. Although this was frustrating, I felt obliged to take account of every contribution however small, whilst tension within the NCWG was also rising.

By August these issues began to escalate. An opportunity emerged whereby with some creative planning we might be able to incorporate some recently developed innovative modules on the topic of "Ageing" from the School of Nursing, which was another School in the Faculty. I saw this as an exciting opportunity to incorporate multidisciplinary aspects of health *early* in the curriculum (Counsell & Sullivan, 1994; Kahn, Davis, Wartmann et al., 1995; Shield, Wetle & Besdine, 2008). Not only had interdisciplinary care been one of our graduate outcomes for the new course but it would allow us to make the course distinctive. Although admittedly a late suggestion, I felt I couldn't overlook the opportunity this unit provided for our mainly medical planning team to collaborate with staff from the School of Nursing. The response from the unit coordinators who were grappling with already crammed timetables for the first year, however, was not encouraging. The subsequent torrent of emails I received from them spoke of the ever challenging task of trying to incorporate an "inordinate amount of material". I was reminded that the unit coordinators were now serving several masters: myself, the five Theme coordinators and increasingly their own heads of department (and direct supervisors), some of whom continued to openly criticize the plans for the new curriculum. It was also pointed out to me that the Theme 1 coordinator was insisting on introducing students to the histology of tissues, cell biology, pathology, microbiology, pharmacology, biochemistry, physiology and human biology, but the other four Theme coordinators too had equally pressing demands on the timetable for the first year of study.

As I read through the long list of concerns sent to me by one of the unit coordinators, I tried to prioritize them according to those which I felt were legitimate and needing immediate action. It was apparent he harbored a greater sense of disquiet about the new program than he was expressing at our regular meetings. I knew he was planning his retirement but felt that his decade of experience with first year medical students should inform our decision making. Some of his concerns could be explained by the fact that he was a latecomer to the planning team and it would take time before he fully understood and embraced the NCWG's vision for the new course. For instance, based on his many years' experience as a teacher of first year medical students, he felt that students would struggle with case-based and small group learning in their first year of study. I, on the other hand, felt strongly that we were selecting capable, intelligent and enthusiastic students who would feel challenged by this approach. Besides, many other progressive schools were using case-based teaching in the first year. Some of his feedback, however, did alarm me, such as the suggestion we had placed too much content into the first unit and the concern that the five Theme coordinators, in their mounting enthusiasm, were potentially "front-loading" the curriculum. "We only have 22 contact hours per week," read one of the emails, "and this applies to all five themes NOT just theme 1...if we attempt to introduce all of the material (from all the "ologies") ...we risk serious overload of the students". To make the point, he went on to say he did not want to "precipitate a major brawl" but felt strongly we were "in danger of losing the plot". I was by now starting to feel overwhelmed. If we couldn't agree amongst ourselves about an appropriate amount of content in the first year, how were we to convince colleagues outside of the NCWG?

Although I was tempted to respond immediately, I felt this was a time for me to remain silent and allow the task groups, the Theme coordinators and the unit coordinators to resolve these issues amongst themselves. Whatever process emerged for resolving this issue would stand us in good stead for subsequent units. I felt the best way for me to contribute was to facilitate ongoing dialogue between the members of the NCWG especially the CCTG and the Theme coordinators (who we agreed were responsible for the "big picture" and ensuring the medical graduate profile was expressed in every unit

of study) and the unit coordinators (responsible for ensuring the delivery of each unit of study through a sustainable and manageable timetable).

Rumours and Myths

In the meantime, the external consultants' review of resources continued from their interstate office with frequent requests to me for definitive figures from the NCWG (such as proposed staff hours and teaching group sizes) in a curriculum planning process that was still evolving. No sooner was a proposed timetable for each unit formulated by the NCWG than it was subjected to the accountant's numerical analysis only to re-emerge in the form of a "cost forecast model" - a format which none of us fully comprehended.

Meanwhile, the local medical political climate was becoming increasingly adverse. The statewide and national shortage of doctors was placing increasing burden on those involved in teaching medical students, particularly in the hospitals, where service delivery was seen as the priority – not teaching. Although the medical school had signed agreements with the State's teaching hospitals which saw funds flow between the university and State Department of Health, most hospital-based clinicians argued their teaching role was being delivered gratis. As part of the statewide debate to manage the doctor shortage, some in the wider medical community began to criticize the new curriculum for its proposed increased use of small group teaching without a concrete plan to independently resource this teaching. The claim was that this style of delivery would create an even greater burden on the medical profession, particularly as the students moved in to the hospitals as part of their training. All I could do was acknowledge that we did need more staff and that significant time had been invested in supporting the independent review of resources which would determine the final teaching staff hours required.

Over time I could see the curriculum being used as a political tool and it angered me. I also became increasingly irritated on hearing unsubstantiated claims about the new course such as the assertion that the course proposed favouring the teaching of

communications skills at the expense of anatomy[30]! Each fortnight we were apprised of the latest "rumour" about the new curriculum from one of the members of the NCWG who also sat on the main post graduate training body for junior doctors in the State. He was also "well connected" with the doctors hospital association who were lobbying for reform in the hospital sector. I wondered about the sufficiency of our communication strategy and our external stakeholder engagement and what else I might do (other than more workshops, web site postings, more frequent newsletters and public presentations) to dispel many of the myths. I was also anxious about the potential for colleagues, clinical and non-clinical, to present the new curriculum in a less favorable light to advance political causes when the AMC visited the School the following year. Also causing me concern at this time were those colleagues who remained outside the reach of our communication strategy who were ignorant of the details of the new curriculum and who remained vulnerable therefore to unfounded rumors about our proposals. I was determined not to allow the past two years of planning to be undermined by lack of communication. I suggested to the Dean we run a "mock" AMC visit in April the following year to better prepare ourselves for the actual visit, arguing that this would provide greater insight into which internal departments and external stakeholders required more focused information about the new curriculum. The idea was thankfully well-received by both the Dean and the School Executive. The plan was to replicate the format of the real visit but condense it into three days. We invited a former AMC accreditor, with many years' experience accrediting Australian medical schools, to sit on the panel as our "mock" accreditation "team". As the planning for this event got underway I was confident this undertaking would not only manage "misinformation" about the new curriculum, but we might also enlist some more support in the process. The consultants' review of resources might also be complete by then, permitting the much awaited open and frank discussion about resourcing the new curriculum.

[30] In fact we were proposing a significant proportion of teaching of anatomy compared with other curricula around Australia and saw this as a particular strength of the new curriculum.

The Scourge of Resources

Resources had always been an issue for Simon. The decision not to have a "gap"[31] year had infuriated many members of staff. The increase in domestic student numbers in 2004 was now being shouldered by the staff in Sandy Cove and this was set to increase further to 110 in 2006 without the hoped for "no-intake" year in between. The only concession granted by the University hierarchy was that 2005 would be a "half intake year", citing financial imperative and the need to maintain a reasonable number of graduates in a climate where doctor shortage was a real dilemma. Simon tried to put the issue of resources into perspective, comparing our plight with other medical schools in Australia:

> I suppose resources to put it [the curriculum] on the ground, that always looked like the problem and it remains the problem...OK, I say it looks the same ... Actually it looks a little worse than it did two years ago - because the numbers game has become more adverse... It would be nice *not* to have had the parallel increase in student intake which makes our task here already greater in resource terms than anywhere else.

When we met in August 2005, with four months until the course accreditation decision was known, Simon still seemed ambivalent about the project he had invested so much time in. Despite holding a senior appointment in the Medical School and being on the NCWG, he was still concerned about resources, this close to implementation, to deliver the new curriculum. Simon's view was that whilst the independent consultancy on resources had partly eased some of his own concerns, this review had done little to build up the confidence of the staff at Sandy Cove who were being asked to deliver the first two or three years of the new curriculum using existing facilities and with no apparent plans to increase staffing. Reflecting back on his position on resources six months ago, he still harboured doubts:

> The question previously of whether resources would be there was a very open one and I think I said last time [previous interview six months ago] that we could only proceed on the sort of assumption that they would be okay... That now does look more likely - I think. The question now is a little bit about how timely that will be - that is *when* the resources will come along and *whether* they will meet the need. I still have questions about that side of things and that's part of the ferment down at Sandy Cove with those who will actually teach the first years... They keep saying "Where is the cavalry", we're told "They're coming" and they are actually looking to hear the trumpets...

[31] Some schools commencing a shorter curriculum have a "gap" or no intake year to prevent two cohorts graduating at the same time and competing for the same pool of internship positions. Such a gap also allows staff time to prepare for a new course.

With the benefit of hindsight, he felt he could have anticipated the additional curriculum requirements himself and provided a conservative estimate of how much this endeavour would have cost. His view was that, in retrospect, we probably didn't require such a radical departure from the existing curriculum and governance structure and that, had we made plans accordingly, we might have contained the expense as well as saving ourselves the significant body of work undertaken by the NCWG:

> If I scratched out to begin with in terms of our resources - we had to be very realistic about what we could provide - it had to be reasonably amenable to our current structure.

Simon articulates his concerns about resources repeatedly. The low points in this curriculum reform process, which for him started in 2001, had all been associated with resources and whether, despite the desire to "innovate", the requisite funds to support the impressive plans could be found:

> The lows tend to be associated with resources I think almost continuously - whenever that suddenly becomes an issue and looks like being a road block again the fear is that it was all going to fall over despite a great deal of academic activity and increasingly as time went by...it could still fall over because there wasn't going to be enough bodies on the ground.

His advice to anyone considering undertaking similar reforms would be to adopt a more conservative approach:

> Cut your cloth to suit your budget and I don't only mean budget in the money sense, to look at what you actually have and make sure that what you do fits with what you actually have... not to be overly ambitious.

Reflecting on other Australian medical schools he had visited (as a member of an accreditation team) whose size and therefore capacity for reform was much greater than this school's, he acknowledged that it was important not to expend too much energy and time on curriculum reorganization and restructuring and to be content to achieve modest progress if that is the best your medical school, given its size and capacity, can support. For Simon it was also important to take time to acknowledge and value the progress that was being made "being happy... relative to where you used to be."

Investing too much

Mary was equally concerned about resources and conscious about the amount of effort she and her colleagues were investing in the redevelopment of the last two years of the curriculum at Northern Clinical School:

> I worry that I think Jenny [a close colleague] and I do it because we enjoy it and the level we do it at is sort of fairly intense. If we were to walk away today what would happen? [The Clinical School] would probably fall into a serious hole I think unless you put in some serious full-timers... so there is a concern for the sustainability of it all. It just takes a lot more rolling out and organization than people ever sort of realized and a lot more time.

For instance, she had introduced reflective portfolios in to the final year of the program as an innovative means of encouraging reflective and critical thinking; however, she was finding the time involved in reading the student's submissions and providing feedback increasingly onerous:

> Like I've marked four sixth year essays this morning and if you do it properly it takes you half an hour for each one and you've actually got to go and meet them [the students] and discuss it with them and then [if necessary] ask them to resubmit it and then remark it....that time doesn't come from nowhere.

Although Mary had acquired an enthusiastic part-time Medical education officer to support her work at Northern Clinical School, who was keen to share the marking load, she felt that the medical students were "educated consumers" who only wanted feedback from someone from the profession. Her core team of medical practitioners was the backbone of her program and without them she felt the program was unachievable. She was adamant she needed more medically trained staff and she was not prepared to remain silent about her concerns. Her mounting frustrations forced her to contemplate strategies she would never have considered in the past, such as threatening to withdraw support for teaching. This was a threat she never *actually* made, and one which her loyalty to the students and the School prevented her from ever making, but one which came to mind often as she continually lobbied in vain for extra staff:

> I will "hit the wall" shortly... That was how it was set up originally in the sense if they [the University] didn't help us we'd pull the plug and walk. Now that sounds very brave because we never would have done it because we wanted the medical school [to survive], but you had to sort of be a 'bit difficult' and play those sorts of games.

Mary felt strongly she had devoted significant time and energy in this project and had brought her colleagues along with her. Her colleagues had been prepared to unite under her leadership for an improved student experience. They had all done so on the strength, it seemed, of a promise from the University to Mary of additional resources – resources which she described as "really basic provisions" and these she felt were not forthcoming. Mary was conscious that her team's goodwill was finite:

> I'm having great difficulty at the moment trying to get enough resources... People [her staff] were prepared to put themselves out in the short term to get things moving... but because these same people wear different hats... in a small country town... you might be involved in the University but you're involved in the [public] Hospital and you're involved in a private Hospital and you're involved in the community all doing the same thing... Their goodwill is exhaustible...and so I think sustaining what you do is probably going to be our greatest difficulty and our greatest hurdle and then when you sort of come up against the governance issues... you become really disillusioned.

Unapprised about the School's plans for resources to support her endeavours, Mary finds herself surrounded with the portfolios of her 60 students, due to be marked by the following week. She is convinced she cannot delegate the task of marking these to her education officer and believes equally strongly she cannot lean on her team of medical consultants who, in her opinion, already dedicate numerous unpaid teaching hours to the program. Consequently, the unread submissions remain on *her* desk until she finds a spare moment. Her parting words, like Simon's, reflect that resources, not lack of enthusiasm for teaching, pose the greatest threat of all:

> There's a difference about doing it well and doing mediocre I think... so that's probably the biggest obstacle, is simply the resources.

An Ailing Hospital and Media Frenzy

In addition to the perceived lack of resources within the medical school, the doctor shortage at the main teaching hospital had also become acute. By August 2004 there had been a series of critical medical consultant resignations, all of whom were involved directly with student teaching. The hospital's Medical Staff Association was preparing to convene a crisis meeting. The August edition of *TasTalk* ran a story entitled "Chaos in the Medical Workforce", the opening paragraph of which read: "Barely a day passes

without some press comment on the flux in doctor supply" and spoke of the potential impact of the "recent departure" of several local specialists and the potential for the State to "suffer serious quality and access problems" (p.3). I received a personal invitation to attend the crisis meeting. When I read the agenda, which included as motions for discussion the view that patient quality and safety as well as doctor training were being compromised by the doctor shortage and that "medical staff must take this into their own hands", my instincts called for caution. I sensed I was being drawn into a political debate which was outside my remit. I was handed the personal invitation by the President of the Association, with the words "it would be good for you to come along and hear the concerns we have". His belief was that the Medical School, in particular the NCWG, was developing the new curriculum oblivious to the impact the new course with its proposed additional student numbers were having on the local health care system, which in his words was "in crisis". I was fleetingly tempted to use the meeting to persuade these doctors of the merits of the new curriculum, which in the long term would not only redress the doctor shortage, but would deliver a world class curriculum in which we could all take pride, though felt certain the questions I would be asked would focus exclusively on resource impact matters and not on quality. I did not yet have the answers to questions such as how many extra medical staff the University was proposing to recruit to deliver the new curriculum; the impact the new curriculum would have on the hospital and the measures that would be put in place to ameliorate this. Furthermore, these were all questions I knew it was not my place to answer. Had they been interested in hearing about our rationale for changing the program, the proposed plans for delivery of integrated case-based curriculum and the incorporation of leading edge assessment plans and heard how these plans had been informed by the latest literature in medical education or interested in hearing the sound endorsements we had received recently from the AMC, I would most certainly have attended. I decided this was going to be a one-sided discussion and so I politely declined the invitation.

I did, however, read about the meeting in the next day's newspaper. The story was entitled "Staff Sound Patient Alert in [Hospital] Crisis" and commenting on the purported imminent closure of the medical school, despite the fact that there were to my knowledge, no medical school representatives at that meeting to make such claims:

> In a dire caution sounded by hospital staff last night, [Southern State residents] were also warned that the University of Southern State's Medical School could close, ending a long and proud tradition of training doctors and specialists.
> (*The Mercury*, August 20th, 2004)

Immediately following this were a series of other headline stories over the next few months which also rumoured the medical school closure, citing the hospital medical staff shortage:

> Southern State's only medical school is close to collapse...The medical school is under-funded and the teaching is at the lowest it's ever been.
> (*The Mercury*, August 20th 2004)

Some of the stories spoke of leading specialists leaving the system "in disgust" and that the hospital itself was "on the verge of losing accreditation". The Medical Staff Association President spoke of the overall state of undergraduate teaching, which relied heavily on hospital-based clinicians to deliver the clinical years of the program, as being dire: "We are just managing to hold it together." In the same story the Australian Medical Association student representative referred to the plight of students of the current curriculum receiving "less than half the clinical teaching required from a tertiary hospital". In another headline story entitled "Doctor Threat on Teaching" came the news that senior doctors were threatening to stop teaching medical students, with a crisis meeting organized with the Health Minister planned to tackle the issue. A number of senior hospital specialist doctors were named (many of the names I recognized as those who had taught me as a medical student), claiming they were concerned about patient safety and the general work conditions at the hospital.

Although I had heard these concerns aired in the corridors of the medical school and occasionally at our NCWG meetings, they seemed more somber upon reading about them through the media. I was concerned about the impact such negative press was having on students of the current curriculum as well as those thinking about enrolling in our new course. I had good cause, for the students themselves were at this time rallying in the Student Common Room to document their concerns to the School's Medical Education Committee. A letter dated 8th September from the President of the Medical

Students Society forwarded to the Medical Education Committee described the students' anxiety:

> As a student body we are concerned at the current teaching status within the six year MBBS curriculum... Staff shortages, underfunding and pressures on doctors mean students miss out. Teaching time is a rare event and this is putting our quality of training/care in jeopardy... It is a concern of the students that the school may lose accreditation by the Australian Medical Council as a result of lacking sufficient appropriately qualified specialists to teach in key areas
> *(Letter from President of the Medical Students Society to MEC, September 8 2004)*

I read the letter with dismay when it was tabled at MEC for I felt the system had seriously failed these young students. I found it difficult to accept that it was really necessary for the issue of hospital staff shortages to be aired publicly, creating the media frenzy that caused these medical students to doubt the quality of their undergraduate training, present and future.

Meanwhile the fortnightly meetings of the NCWG continued on the 4th floor of the Clinical School. By now most of our meetings began with a discussion about what pre-eminent clinician was talking of resignation. Two of our NCWG members were active clinicians in the teaching hospital and were in regular contact with all developments. I persisted in the view that these political matters were outside the remit of the NCWG. Nonetheless we were all quietly concerned about planning a curriculum in such a hostile and precarious environment. We needed to forge ahead though, regardless of recent political pressures, and seek full accreditation for the program which could always be shelved for a while if the workforce issues remained unresolved. Secretly I hoped this recent political upheaval might focus the agenda constructively around resourcing the new curriculum which did after all, concern us all, if as was being suggested it meant we could not proceed with the new course in 16 months.

The August edition of *TasTalk* provided the first public reference by the Dean to the expected date for the handing down of the results of the much awaited independent

review of resources. We would have an interim report in September and a final report in December to go with the final Stage 2 submission. At last we would have some answers.

Rising Tension within the Group

The hospital resources debate continued through the following months but I gradually became immune to the stories of key hospital staff resignations. In mid August the University had unveiled its plans for a $42 million upgrade of the medical school premises in the city centre to coincide hopefully with the launch of the new curriculum. I felt this news went some way towards countering the negative press regarding medical staff shortages so I posted the notice all around the medical school in a spirit of defiance. In that article the University Vice Chancellor was quoted as saying "the revamp would give the university world-class facilities and he expected it would help attract more specialists to the State" (*Mercury*, August 19, 2004). I again felt vindicated that the new curriculum along with improved premises to support medical research would play a strategic role in attracting doctors to the State and address many of the concerns being canvassed through the local media.

In late 2004 we identified two new unit coordinators for the second year units which meant the MEU project officer based at Sandy Cove was now supporting four part-time academics. My plan was that these two new appointments would support the first year unit coordinators and I hoped that the concerns expressed to me in recent months about curriculum load in the first year would settle. I also felt that as we were building a critical mass of support in Sandy Cove where the first two years would be enacted many of the concerns expressed by staff in that location would be alleviated. And I felt it was time to direct some more of the NCWG time to more "hands on" support of the development of the first two years. It seemed to me that as we now had four unit coordinators fully occupied developing detailed content of the first two years that we should consider temporarily shelving the Curriculum Content Task Group (CCTG) who had independently moved on to plan the third year (which was four years away). I suggested we temporarily disband the CCTG and focus our combined energy on planning together the details of the first two years as I didn't want our planning to get too far ahead of itself. The rationale was simple - we would use the next few months to

get our concrete plans for the first two years on paper in preparation for the AMC visit in May 2005 rather than spreading our resources too thinly across the three years and risk not convincing the AMC of our capacity to deliver on time. Years four and five of the new curriculum were meanwhile developing steadily under the enthusiastic direction of the SWCSWG, who had by now embraced the Medical Graduate Profile and many of our suggested assessment strategies. This meant that, after the visit in May 2005, the NCWG could focus on developing the outstanding content of the "middle" or third year. The two leaders of the CCTG would trade their "big picture" roles for a more "hands on" role supporting the unit coordinators. Although I had majority support, not everyone agreed, least of all the two leaders of the CCTG, who had been two of the original members of the NCWG.

Whether it was this particular decision or a series of coinciding events I was never sure, but from this point on the NCWG entered its stormiest phase yet. We continued to diligently document everything in preparation for the submission and each of the minutes contained specific action items for the 17 members of the NCWG including the two medical students who had joined our ranks. I started to receive unsettling emails from members of the group, particularly the unit coordinators who were, in addition to our fortnightly NCWG meetings, also regularly attending local meetings with their teaching colleagues in Sandy Cove (whose preoccupation remained the existing course) in an effort to include agenda items regarding the new curriculum and thereby persuade colleagues to embrace the new curriculum. Without their colleagues' support and input, the task of drafting realistic timetables for the new curriculum and the case-writing which needed multidisciplinary input, could not be completed. All of this the unit coordinators were attempting to do alongside their other teaching commitments. The communications to me highlighted mounting concerns particularly over time pressures. One email read: "I express concern with the amount of time available for curriculum writing given the extensive commitments to other aspects of developing the new curriculum." In addition to this, I was trying to manage growing tension between the recently "retired" leaders of the CCTG and the unit coordinators. The issues were presented to me as being the result of "lack of direction/communication" between the various curriculum development teams. I wondered whether the group, which was now

12 in number (and on some days more depending on who I had invited to "sit in" and whether our student representative attended), had become too unwieldy, and yet I felt we needed the support of everyone around the planning table. In a piece of correspondence tabled at our September 2004 NCWG meeting the growing tension between members of the group was apparent:

> Ongoing discussions with the unit coordinators and members of the NCWG have highlighted that the process of translating the weekly cases and learning objectives into a timetable have become problematic...

I myself was beginning to find the pace arduous. From without I felt we were under continual scrutiny by our hospital-based colleagues who were embroiled in a bitter dispute over staff shortages and who felt the development of a new medical curriculum with increasing student numbers was a major distraction, and so refused to engage with the planning. The lack of detailed information about resourcing the new curriculum meant I could not confidently counter any criticism from my clinical colleagues. The medical students themselves were anxious and concerned about their future training in the State. From within the growth in membership of the NCWG, particularly the appointment of now four additional unit coordinators who were geographically separated from the other members of the NCWG was creating additional complexity for me as coordinator of the project. I sensed a drift between some of the original "foundation" members of the NCWG and the recent unit coordinator appointments. This drift seemed to be caused by a sense that the original vision for the curriculum was being somehow lost in its translation. Overall I felt we needed something that would help reignite our enthusiasm for this project and help place the recent political events into context.

A Historic Moment and Brief Interlude

I decided the School should host an historic reunion of the former Deans of the Medical School to try to redress the negative press and restore our faith in the planning process by reflecting on the School's history and tradition. I knew four of the School's former Deans resided in the State and when I distributed invitations for the afternoon seminar they all accepted, including one of the foundation professors who was the architect of

the original curriculum. As the School was 39 years old I entitled the presentation "Forty Years in the Making...the Southern School of Medicine". To my surprise the audience exceeded the capacity of the tutorial room we had booked. I had not expected such an overwhelming interest from staff and students. By the time I arrived to introduce the speakers there was standing room only. I took the opportunity to make some opening comments with reference to what I felt was a timely reminder that the goals to which we aspired in the new curriculum were not new. I quoted a previous University Vice Chancellor who in the 1950s described the ideal medical graduate as someone motivated by a sense of duty and love of knowledge for its own sake. Continuing in my own words I spoke briefly of the work of the NCWG:

> Those of you familiar with the concept of the Medical Graduate Profile and the five themes underlying the new curriculum will know that these ideals remain a key focus... Now is probably an opportune time to reflect on the school's origins, to pay homage to the school's founders and to express our ongoing commitment to the liberal and quality education of tomorrow's doctors.

One of the guest speakers, who was a psychiatrist with an interest in medical history and had published a book about the school's history, acknowledged the great pleasure it was to be standing in the room with such a distinguished panel of former Deans. He also pointed out that he had never seen this particular meeting room so full of students! I felt a little disappointed the current Dean could not attend the presentation or the photo opportunity which I had arranged to follow. He was attending a Planning and Resources meeting.

Students in particular arrived in large numbers and many were forced to sit on the floor as they listened attentively as the former Deans took turns to relate humorous and self-effacing anecdotes about the School's history. These accounts seemed to me to immediately restore the pride of those assembled and for a moment I was able to put the recent trials and tribulations, including what I felt had been harmful media coverage, into perspective. Many of the academics who attended, predominantly clinicians from the main teaching hospital, were former graduates of the School and also contributed their own accounts during the session. The seminar went over time but no-one seemed to mind. For a brief moment it seemed to me we all lost the fervour of the political battle which saw us take sides on the issue of the resourcing of medical training at Southern

State. I found it humbling to hear about the school's early days spent in demountable RAAF buildings on the Sandy Cove campus and the valiant efforts of predecessors to establish the medical school and overcoming difficult obstacles to achieve this including political factors and financial constraints.

The local University newsletter as well as the AMA newsletter ran a short story and the photograph (which I still cherish) captured the four former Deans sitting in the foreground and several senior members of faculty in the background including myself and two other members of the NCWG. I was quoted in the article that followed as saying:

> Dr Geraldine Mac Carrick (Head, Medical Education Unit) described the seminar as "a rare opportunity indeed for some of the foundation academics to share their personal accounts of curriculum development with the current new MBBS curriculum development team, and students of the current course forty years later. The presentation reinforced that many of the challenges of curriculum development we experience today such as ensuring the curriculum is not just about imparting factual knowledge to students but the love of knowledge for its own sake, integrity, the capacity for critical and reflective thinking and developing a social conscience, were the very same challenges faced in developing a medical curriculum forty years ago."

One of the students who attended the session was our student representative on the NCWG. He had made a significant contribution to our thinking in terms of providing the student perspectives on case-based learning in the final two years of the program. He had enrolled in the Graduate Certificate in Teaching and Learning as well as his full time load as a medical student and I felt certain he would make a significant contribution to medical education in the long term, once his studies were completed. I was keen he be part of this historic photograph and so, although contrived, I called him over just in time to stand next to the other member of the NCWG. He was quoted in the same article as saying:

> It is good (for us) to know that even though the medical school faces the same challenges now as it did 40 years ago, it has still consistently produced graduates whose qualities are recognised at a national level.

In reading his words I felt my fervour for the new curriculum restored. All that had been undone was restored and we could continue the battle once more.

The SWOT Analysis

Feeling buoyant again, I commenced the task of formulating the school's "self study", which was to form part of the Stage 2 submission. This required the school to reflect on its own perceived strengths and weaknesses. We discussed the process for compiling this document at length at the NCWG meetings and one of the members felt strongly that the best way to proceed would be to interview mainly members of the NCWG, because it was agreed that the submission should also focus on the perceived benefit of introducing the new curriculum, therefore requiring a knowledge of the proposed plans for the new course. In the spirit of democracy, I cautiously agreed this seemed a reasonable approach to the task because the other members of the group were unanimous in their endorsement. Eight members were identified, most coming from the NCWG. As time went on the view was expressed that these interviews form the entire basis of the SoM self study and that they not be "edited" by anyone, particularly senior faculty. I was increasingly troubled about the rationale for this approach. This suggested a distrust of senior management, which would only serve to distance the NCWG from senior faculty. Whilst it was true we had received little explicit support from senior executive apart from the Head of School, whose vision this new curriculum represented and with whom I enjoyed regular and supportive lines of communication, I had come to accept this relationship for neither were we experiencing any interference with our work. I now felt some of the members of the group were becoming obdurate and inflexible. I wondered whether this in part reflected the recent addition to membership, which was creating a new dynamic in the NCWG. With politics all around, this recent dynamic seemed to want to politicize the planning process as well – which was the very thing I wished to avoid from the outset.

When the transcripts were eventually circulated, they were not as controversial as I had expected. The most significant of the School's identified weaknesses related to the small size of the School and therefore limited resource base. I was pleasantly surprised by some of the comments by other members of the group which talked of our coherent

process for developing the curriculum and our "solid set of graduate outcomes". Several of the interviews spoke with assurance about the process we were using for generating the new curriculum as something that was "actually working very well". Others talked about enjoying the process of defining the detailed content for the first year as "putting the nuts and bolts into the first block" and that as a consequence there was increasing confidence that the process we were using would work well for the ensuing development phases of curriculum development: "We know we can do that so there's no reason theoretically why we can't continue to do that for the rest of the course." This was the first public endorsement I had read from the membership of the NCWG that everyone felt we were on the right track. Reading the responses, I felt vindicated in the unpopular decision I had taken to shelve the CCTG and focus efforts on the detailed planning of the first two years.

To Step Down or not to Step Down

I had been too hasty in drawing the conclusion that all was well within the group, however. The tension between the CCTG and the unit coordinators over the translation of the original vision for the new curriculum (as defined by the original membership of the NCWG) continued. The submissions I received for the September edition of our MEU newsletter - *Catalyst* – contained a short entry from one of the team that offered a clue as to how some of the group were really feeling at this time: "An integrated curriculum is coming together, but we have to be vigilant as we don't want to lose all the previous good work in the translation".

Oblivious to the extent of the dissatisfaction, I found myself in a difficult situation on the morning of the 6th October 2004. I received an unexpectedly late apology for our scheduled NCWG meeting from three active members of the group, two of whom had been the leaders of the CCTG. The three members had left the message to be passed on to me as Chair that they were held up making a separate submission to the Dean documenting "their concerns" about the process of the group which they felt could not be dealt with in the meeting. I was completely taken aback. I decided to continue the meeting regardless as my efforts to convince the vetoing members by phone to rejoin the group failed. In an instant I felt a dark cloud had descended on us. The rest of the group

was left to continue our meeting with an unpleasant air of conspiracy. Although nothing was said, I suspected a vote of no confidence in the process and in me was about to surface. I felt decidedly uncomfortable and for the first time had been taken completely by surprise by what seemed to me an irresponsible and ill-considered decision by three of the group. My surprise was also based on the fact that I had presumed that by now the NCWG, which had been meeting regularly for over two years, were well past the "storming" phase of Tuckman's five stages where power, decision making and interpersonal relationships usually emerge as issues.

Nonetheless we clearly had a problem which needed decisive action. I suggested an immediate meeting to be facilitated by Simon, the Chair of the MEC, given our relationship with this committee. He reluctantly agreed. I also recommended a minute taker to document the concerns raised at the meeting which we could then take away and consider privately and put solutions in place quickly. I felt we could ill afford to lose valuable time at this stage of the planning process. Furthermore, three disgruntled members represented a significant proportion of the entire NCWG.

By the afternoon I found myself sitting in a student discussion room of the medical school library (next door to the private collection room where I had spent many hours the previous summer). Across the table from me sat the three other longest-serving members of the NCWG. Simon, in his capacity as facilitator, sat at the top of the table and gradually drew us into discussion. It did not take long for the issues to emerge. The list of concerns which had clearly been brewing for some time was placed on the table. They included the "rapidly changing face of the NCWG" which was perceived as having altered significantly from its original purpose and had expanded to include a membership which was not exclusively focused on the activities of the new curriculum (for example some administrative members were engaged in preparing the submission and others on curriculum evaluation); the concern that more "thought and energy ought to be directed towards realistic assessment of the resourcing issues pertaining to the new curriculum"; the concern that decisions of the NCWG were being "made in haste" without sufficient time for consultation and specifically that I as Chair was not taking into account the interests of all the group; the concern that insufficient discussion time

had been allocated in recent meetings to considering the impact of staffing levels at the local hospital, which was felt to have a direct bearing on the School's capacity to deliver a curriculum in 2006. One of the concerns I predicted was the recent role reshuffle which saw us focus more on the first two years. This was felt by the two academics affected to have been "unwarranted" and that focus on maintaining the "overall strategy...should be maintained as the priority". Concern was expressed at the lack of clarity around operational authority and the blurred relationship between the NCWG and the overarching MEC. The overwhelming concern was around the perceived need for the "originally constituted NCWG" (namely the three members and myself) to maintain "ultimate control of the direction the New Curriculum was heading".

I felt nauseated and completely overwhelmed as three colleagues faced me across the table in unprecedented exasperation and voiced their concerns directly at me one at a time. Nothing I had read in the literature prepared me for this day. I tried hard to maintain my composure. As a hospital administrator I was familiar with the principles of conflict resolution and so calmly and systematically I attempted a reply to each of their concerns. I kept telling myself this was not a personal attack. On a few occasions Simon had to intervene as facilitator to keep the discussion focused and composed. He was capitalizing on the esteem with which the rest of us held him to steer the heated discussion away from the controversial and emotive to the impartial and the detached and to bring about a practical resolution. I was particularly grateful for his direction during the meeting.

In my defense I spoke of the membership of the NCWG now reflecting the inevitable growth of the curriculum development team, and how I felt this expansion to be a positive development. I spoke of the need for tighter deadlines to be applied as timelines shortened and that this necessitated a different management style, as well as a different approach to decision making on the part of all members of the NCWG. Regarding the need for control by the "originally constituted" members I was not at all in favour of this suggestion which I found self-indulgent and shortsighted. I felt the group had legitimately grown and the current NCWG membership, which now stood at 15, reflected the growing interest in the new curriculum of which we could all take pride.

The new members' contributions were all valuable and worthwhile and helped expand the vision of the original team. I did not express these sentiments during that encounter for it was clear my views were at odds with theirs; however, I felt confident this was not the unanimous view of the NCWG. This was an issue over which I was not prepared to compromise even if it entailed my having to resign from the process. The success of this project was based on inclusivity not exclusivity and I was determined this was the only way we would engage the greatest number of people in the short and long term. I firmly believed the curriculum belonged to everyone and not a select and elite few, no matter how tirelessly they felt they had worked for the new curriculum for the previous two years.

The whole meeting appeared to reflect the very real sense of disempowerment and frustration that these three academics were experiencing. After my shock and disbelief settled, I felt saddened that after two years of diligently working together we had come to this. It seemed to me we were disagreeing over something as trivial as where the "control over the direction of decision making" should reside. I tried not to personalize the issues, reminding myself how conscientiously these three academics had worked in meetings, workshops and forums to develop the new curriculum, generating numerous discussion papers and trying to engage a largely resistant assembly of academic staff both in the hospital and in the medical school. I also tried to imagine the toll the recent negative press about resources was having on staff morale, including theirs, and take into account the fact that not everyone was as certain about the timely arrival of a solution to resourcing the new curriculum as I. Nonetheless I felt deeply shaken and upset by this dramatic turn of events which in part questioned my leadership style, indeed my authority to lead and coordinate this project. We concluded the meeting with two "action items", namely that we seek the Dean's clarification regarding current roles and responsibilities within the NCWG including the membership and that we allow for more "brainstorming" and discussion during our fortnightly meetings.

I returned home that night emotionally exhausted and spent the next week carefully dissecting the discussion and the events of the previous months. I wondered how I

missed the warning signs and whether I had been setting a pace which had been unsustainable.

I went back over the minutes and agendas of our meetings over the previous months and read through my emails. I unpacked my files from the start of the project and reviewed the PowerPoint presentation I had delivered to the NCWG in November 2002. My slides had spoken then of the need for a "mature group process " to prevail, which would provide a mechanism for feedback; clear decision making processes and maximum use of member resources; a clear communication strategy; a participative leadership style, and an exit strategy for all members, which did not entail a "fall from grace". I also retrieved the notes I had made to myself on change management in preparation for my selection interview two years ago, which articulated the need for "open consultation"; "an understanding of the current culture and politics"; "the setting of clear objectives"; "an effective communication strategy"; "the setting of an appropriate pace of change"; "the need to manage uncertainty" and "the need to support key power groups and support staff during change". I felt on reflection that my approach had been stronger in some areas than others. For instance, I was confident I had done all I could to maximize use of the group's resources and my strategy of growing the group size to over a dozen was in keeping with management research findings that larger groups (12 or more members) are good for gaining varied input and engaging in problem solving (Robbins, 1994 p.392). In the formative months I had little choice about group size as no-one else wanted to join our ranks. In retrospect this was probably in our favour as the smaller size meant we were more effective than a larger group would have been at completing specific tasks such as defining the key pedagogy of the new curriculum and the exit outcomes. The rationale in expanding the group was my attempt to keep the group diverse in terms of a mix of clinical and non-clinical staff, also to ensure representation by varied group of disciplines from ethics to administration and to anticipate the natural attrition we were experiencing owing to competing workloads. This was also in recognition of the management research findings that showed that the most consistently successful groups comprise a range of roles undertaken by various members (Belbin, 1993) and that heterogeneous groups (in terms of abilities, personalities and experience) generally perform more effectively than those that are homogeneous (Robbins, 1994). I was also quite proud of the communication strategy I had implemented through regular

workshops, forums, newsletter and the dedicated website which delivered a consistently positive and transparent message about the new curriculum and attempted to address concerns staff might have about the new course and what the underlying pedagogy entailed (Kreps, 1990; Robbins, 2006). However, areas where I felt I had possibly been deficient were in underestimating the need for a more modest pace of change. Although I had relied on the use of regularly interspersed deadlines (Gersick, 1991), these were clearly starting to exceed some members' capacity to deliver and there was insufficient time for group "brainstorming" new ideas. What concerned me most after that meeting were the criticisms about my leadership, in particular the suggestion that my style, despite my best efforts, was not perceived as participative (Yukl, 1994; Bass & Riggio, 2006) and even more concerning that I was operating without operational authority.

After four long and lonely days of deliberation, I hoped to receive some sign from the School's executive that my leadership of the group was secure. I finally decided that my best recourse was to tender my resignation to the Head of School and allow him to appoint a new Chair. This would allow me to continue on the project "behind the scenes". I felt that unless I received unequivocal top-level support for my role now, it would be untenable for me to continue and I felt that this decision should be reached quickly. Perhaps after two arduous years chairing the group, it was time for me to step aside and allow a different leadership style to prevail. My letter read:

> One of my proposed solutions is to step aside from the "hands on" leadership role I have provided in the past two years ...and to delegate the chairing of the NCWG to other members of the team

I went on to point out that although this measure would entail short-term disruption and additional workload for some members of the group, it would nonetheless "prove valuable" if it "restored a greater sense of ownership". I met with the Dean after he had time to consider my letter. The suggestion that I resign or step down from any of my current roles was firmly refused. He decisively pushed my letter of resignation back across the large oak desk and adamantly refused to speak further on the matter.

The next meeting of the NCWG went ahead as scheduled in a fortnight. The Head of School attended, expressing his disappointment that this "unpleasantness" had not been

resolved "in house". He quickly went on to endorse the excellent results we had all achieved together and expressed his desire to keep the current arrangements in place, "at least for the time being". The group looked bewildered and chastened and we nodded quietly. I felt that no one had emerged from this having achieved anything but the status quo. Although I could not reasonably have expected any other outcome from this meeting, I still came away feeling somewhat cheated. In part I felt it would have been preferable to have had my resignation accepted than being left "in charge" with such an indifferent endorsement from the Head of School. I understood the need for close cooperation between the Head of School and recalled my reading of the literature which spoke of the need for the Director of Medical Education to have the "unqualified support and confidence of the dean". No doubt he himself found this an awkward situation to manage with serious discontent being expressed by another two of the team he had originally appointed.

The tone of the subsequent two NCWG meetings was more subdued than normal. A month later, two of the three discontented academics had resigned from the NCWG, both to projects, I later found out, they had been considering for some months. My sense was that they had found the group's expansion too difficult to come to terms with and the need to accommodate increasingly diverse member perspectives as well as continually modify the original vision for the curriculum all too challenging. There was really little I could do to address the concerns they raised at that meeting in the library. Apart from allowing more time in our scheduled meetings for "brainstorming", which I immediately put in place – the relationship between the NCWG and the overarching MEC remained unchanged: I continued to provide leadership of the NCWG, there was no "inner group" set up to sign off on NCWG decisions and the issues relating to resourcing the new curriculum remained a matter for the School executive. I was, therefore, not surprised when two of the academics eventually announced their decision to separate from the group. I felt this whole ordeal had been a particularly low point of the project for all of us. Both academics had been there from the start of the project. That original group of five (of which now only two remained) had been for a time, I felt, a very cohesive group that had shared the best moments planning the original vision. There had been no "social loafing" (Ivancevich, Matteson & Olekalns, p. 266-267) in

this group, for I felt we had all worked extremely hard and together had endured many ordeals. But then this was true of all the members of the group and not just those who had been there from the start. Perhaps we were all suffering to some extent from "role ambiguity" (Meudell, Callen & Mullins, 1996). I certainly felt there remained some lingering lack of clarity around my position as the Chair. I also felt that we were all experiencing – to some extent – role overload.

The two academics who had taken the decision to leave the group after nearly two years were reminded of the indelible "footprint" they had left on the curriculum. As with the other members who had stepped down from the NCWG in the previous two years, I was keen to remain true to the guiding principles of an exit strategy for *all* members which did not entail a "fall from grace". The group thanked the members involved sincerely and again an offer of a place around the table should they decide to return, was made.

Although I felt this separation profoundly, more so because I felt it should have been avoided, the air had cleared after their departure. As I looked around the planning table with still 13 dedicated members of the team looking for someone to lead them to the finish line, I quickly re-asserted my authority as Chair of the NCWG and we moved forwards again.

Men Overboard

Not everyone felt as intensely about the events of October 2004 as I had. Simon had endured his own personal low points but had always been able to put them into context. "There were a number of low points," he says, then adds looking knowingly at me, "You will remember yourself at which point these arose as issues... because of the pressure". He was referring, of course, to that meeting in the library in October, which he had been asked to facilitate. Simon is candid in his analysis of the impact this curriculum planning and reform process is having on his colleagues. In the same way he described his involvement in the project from the outset as "inevitable", he now describes the impact of change as "unavoidable" and a "constant" in the modern day academic's professional life:

> This is part of the process of change management. It is... a societal cultural thing in that change is now a more constant thing. You can approach this in change management terms by trying to build the idea that it's always going to be changing, 'Sorry, it's never going to sit still and we can all relax, life just isn't like that anymore.' Or you can say 'Okay we will sort of cast it in stone for a while and we'll have a big change every so often.' They both seem problematic to me and I think probably the reality is... constant change.

Simon is also pragmatic in his interpretation of how he has seen change alter the lives of his close colleagues in the medical school:

> Yes, it [change] does make everybody weary at times, it tires people out, it probably accelerates turnover in that sense and you probably just have to accept that it is one of the things that's different about the world that we live in.

Yet he seems able to "clinically" detach himself from the events around him and does not seem to harbour any long-term misgivings about the men we "lost overboard". He is matter-of-fact about the events leading up to the two resignations in October: "If you are turning people over, that isn't necessarily a bad thing... You need a mixture of people who have a body of experience about corporate knowledge, but you also do need new ideas and new energy so turnover is going to be inevitable... and men will be lost overboard. As long as you can replace them, then that's fine... It's good in terms of self-examination, you get some renewal."

The Vice Chancellor has the Final Word

I had made a mental note to allow more time on the agenda for discussion, but things quickly resumed the same pace and level of activity as before. The next critical workshop, which had been on the planning table for several months, was the long-awaited presentation of findings by the external resources consultancy. The Vice Chancellor of the University had been invited to be present at this workshop as were senior members of the Department of Health. The key outcomes the School sought from this strategic workshop was to encourage these two sets of stakeholders (University and Department of Health) to publicly agree on adequate resourcing of the new program. The meeting, which the MEU organized, was attended by 50 senior delegates and was

by private invitation only. This was the first time in Australia that such a formal review of resources had been undertaken by a medical school.

The key dilemma was that the School could not be certain of its accreditation until the end of the following year (following the AMC decision) and this decision was dependent upon adequate resourcing of the school (the new building and the new curriculum) by the University and the State. Those of us present waited patiently for the delayed arrival of the Vice Chancellor from overseas. It was critical he attend. When he finally arrived, the meeting got underway. The Secretary for the Department of Health and Human Services spoke of the "strategic importance" of a medical training program in the State and the Dean spoke about the "strategic significance" of the new medical curriculum. As the day wore on, the much-awaited definitive commitment from the stakeholders did not eventuate. Neither did the authoritative cost of medical education in the State, though we all endured a long session on the terms of reference of the resource consultancy group and a lengthy description of the metric they were using to cost the new curriculum. Over the tea breaks the topic of conversation turned to the latest reporting of the medical school in the weekend press. One story, entitled "Medi-Bank", claimed that fee-paying international students were being used as "cash cows" to prop up the University. The other report entitled "Medicine's own Malady" referred to secret "internal documents" which had been acquired which described a series of "in-house" issues within the School such as the "lack of doctors to teach students" and a "lack of patients" to match the large numbers of enrolled students. There was also a reference in the media report to the pace of curriculum reform and lack of planning which related directly to my area of responsibility:

> "Internal documents show the medical school has been hit by:
> - Increased numbers of students both domestic and international
> - Inadequate resourcing of the School
> - Resourcing and staffing problems at all three major hospitals
> - Too much curricular change in too short a time
> - New methods of teaching which are poorly understood by some clinicians
> - Lack of planning and consultation with regard to change"
>
> *(Sunday Star, October 31, 2004 p.8)*

Everyone I spoke to mused as to where these "secret internal documents" had come from and once again the medical curriculum planning process was being politicized. The following week, a 1,000-word email came to all staff in the School from the Vice Chancellor in an effort to redress the negative coverage the School and the University had received. The email began with:

> As part of the School of Medicine's curriculum planning day, it was a pleasure to speak to some of you earlier this week about the exciting developments that are underway to ensure we have a vibrant and world-class medical school for generations to come. Media reports last weekend implied that the School was in some form of crisis – being starved of funding and forced to take in excessive numbers of students without adequate provisions of resources by the University. I am very happy to report to you that nothing could be further from the truth.

His note to all staff went on to acknowledge that the School was in the midst of a period of significant change:

> no doubt the biggest since its establishment. But, rather than being chaotic change, each aspect of change is part of a comprehensive strategic plan that has been designed to ensure the viability of the School into the future.

He went on to describe the context of the change referring to the need to provide "first-class medical education and training", and to conduct "ground-breaking research to improve the health and wellbeing of citizens in communities near and far" and that in order to achieve these outcomes we would need "excellent teachers and researchers, talented students, good facilities, and sufficient resources to invest in all three". He spoke of the drivers for the change in the medical school such as the Australian Medical Council which had made it clear in each reaccreditation review since 1991 that "fundamental change in a number of areas was needed to ensure the viability of the program".

I continued to read his note in detail and found it encouraging to think that the Vice Chancellor would be this familiar with the work we toiled over for the past two years. He spoke of the significant efforts to implement change and that this had been "ramped

up'' in order to guarantee continued professional accreditation" and then spoke of the inevitable impact this would have on staff:

> As we all know, any significant change management exercise is going to involve concern, tension, suspicion and resistance. On the other side, it should also be exciting and invigorating – enabling new ideas to come to the fore and new possibilities to be explored. Some of us will experience more of one side of the coin than the other.

I felt certain that, particularly given the events of the past month, some people reading this email would agree undeniably that they had experienced "more of one side than the other". Further down the page the Medical Education Unit was given a specific mention for the significant role it had played in redesigning the curriculum and that it was "well on track to have the new course ready for AMC approval in 2005". He thanked everyone who had played a part in constructing the new course:

> I'm sure you will agree with me that this student-centred, case-based model will be attractive to potential students, the medical profession and the community at large.

He then went on to dismiss the claim that "the School was being starved of funding by the University", referring to this as "a good headline grab, but one lacking any substance".

I read the email aloud to myself several times as I sat at my desk, pondering how long it must have taken to compose this piece of correspondence. I felt a swelling sense of personal pride in my work and restored faith in the organization which I felt certain now would find a way to deliver the promised resources. This strategic communication provided the much needed impetus to spend the whole of the summer of 2004 preparing our most significant document yet, the Stage 2 submission, which was to be dispatched, accompanied by the resource consultants' analysis, in late January 2005.

Summary

By November 2004 we were two months away from our final submission to the AMC. This document needed to contain our final synopsis of the proposed new curriculum detailing the vision, objectives, pedagogy, assessment plans and detailed timetables for four of the five years. Further setbacks were experienced in the month before with two further resignations representing a loss now of in total three of the five original members of the NCWG. Despite this loss, the overall membership of the NCWG continued to slowly expand. During this time the medical school had also become embroiled in a bitter political battle over State-wide medical workforce shortages which saw the promulgation of several unfounded and disquieting rumors about the new curriculum. The simultaneous media coverage did little to engender confidence in the planning process as we set out to make our definitive submission to the AMC. My leadership of the NCWG came into question during this phase, as did the process of decision making within the group and the question of control of the direction of the new curriculum. During this period I felt the NCWG processes under siege from within and without. The loss of two more foundation members, I felt, should have been avoidable. I had assumed we as a group had moved past the "storming phase" (Tuckman, 1965) and found this period of internal group conflict entirely unexpected. I had come to expect resistance, conflict and opposition from outside the planning group, but I had not expected such a measure of discontent to surface so late in the planning process, from within the NCWG. Equally perplexing was the timing of the decision by the two academics to step down so close to our reaching a landmark milestone in the project.

Although my own leadership style had been called into question, I still felt the pressing need to persevere with the approach I had adopted of engaging as many staff as was possible, no matter how small their contribution. I did not accept the view that decision making remain the remit of a chosen few. We had committed ourselves now to significant (as opposed to incremental) reform of the curriculum and all that that

entailed, and I felt the only recourse now was to engage as many people as were interested in participating in the planning and to keep moving forwards. The long-awaited independent review of resources did not provide the level of detail that was anticipated; however, a landmark communication by the Vice Chancellor to every member of teaching staff at SoM made a public and earnest commitment to supporting the new curriculum, and indeed the medical school, for generations to come.

Chapter 8 – Under Siege: Soundings from the Past II

Soundings from the Past

The story is again intentionally interrupted by the voices of past Deans. Curriculum reform and accreditation matters featured in all of their accounts. In 1965 the concern was whether the School would be accredited with the General Medical Council of the United Kingdom. In subsequent years (when accreditation of Australian medical schools became the remit of the AMC), each Dean had cause for dialogue with this external body. Each review by the AMC since 1991 recommended serious reform and each successive Dean tried his best to overcome the many barriers to implementing these reforms and achieve a satisfactory outcome for the School.

Academic Dean (1991-1994)

A Dearth of Evidence

Professor Samuel elected to meet me in the medical school as he had wanted to drop by and visit an old colleague whilst he was there. A friendly unpretentious man, he openly described himself as a "bit of a traditionalist". Although a pharmacologist by training he had been "converted" [by his predecessor Professor Conroy] to physiology twenty years earlier "by total immersion". Professor Samuel had started his career as a lecturer demonstrating in physiology and pharmacology and over the years had become increasingly involved in the administrative affairs of the medical school rising to the rank of Academic Dean over the course of 20 years.

During his time as Academic Dean a landmark study of the School had been completed by two of its senior staff. A paper in the Medical Journal of Australia described the final destination of many of the School's graduates (Vial & Muller 1998) since the School was opened. The achievement of the School's graduates since 1965 was impressive and formed the basis for a significant counterargument to those who advocated change. This study showed that College fellowships had been obtained by 56% of SoM

graduates and other formal postgraduate qualifications by 24%; MDs or PhDs by 7%, senior hospital appointments by 46%, and senior university appointments by 21% with 30% of graduates having published in the medical literature. Professor Samuel was proud of the School's achievement and viewed this publication as "a very powerful potent argument" at a critical time in the School's history. He struggled to "sell" the reforms advocated by the AMC during his tenure as Academic Dean, making the distinction between "process" and "outcome":

> At the time we were under threat... We'd been criticized [by the AMC] heavily for the process but the outcome was very dramatic - in a sense that was what the paper showed... I've forgotten the figure but something like [our graduates were] four times more successful in the specialties and higher degrees than any other Medical School in Australia and that was a very potent argument for not changing and indeed we were I think quite honestly arguing from that point of view - if the outcome is good which it is... why do you want to change?

He felt at the time there seemed a dearth of evidence for the new educational reforms being advocated which was at odds with a profession that was founded on "evidence-based medicine":

> The current professional's thinking is 'evidence-based medicine' you see and there's a lot of non-evidence-based medical sort of stuff going on in the [medical education] community at the moment... anecdotal thoughts driving curriculum review... and that will inevitably lead to disaster because you can't have an evidence-based system of medicine without evidence... real evidence and that's of course why research is so important.

Professor Samuel felt strongly that the reason the School's graduates had done well was because the School's approach to pedagogy had been soundly based. His opinion was at odds, however, with the prevailing opinion outside the School:

> Then the criticism was well that... the process is all wrong, you're not giving students a chance to be creative and to think because it was largely didactic teaching, examinations were to a large extent factual recall and that sort of thing. No one knew what summative assessment was really and so it was very much the British tradition which seemed to have worked... My problem was...do you throw the baby out with the bath water?... This was my conflict... and yet I could see you had to do it, you know we had to go through with [the reforms] because not to would have meant... closure of the Medical School.

Acting in the Best Interests of the School

In trying to enact the reforms expected by the AMC at the time, which included more integrated teaching, less didactic teaching, and more opportunity for self-directed learning, Professor Samuel struggled to accommodate everyone's wishes. None of his colleagues wanted their discipline area affected by the reforms. The most difficult challenge Professor Samuel faced was that in particular no-one wanted to lose any time allocation in the existing curriculum. All of his colleagues saw their particular contribution to the curriculum as unique and essential:

> Well I suppose if you ask any academic that he'll say "Yes, my area [is critical]" and that's the problem isn't it? There was someone I met in the corridor a minute ago as I came in - I hadn't seen him for years – but that man I remember as passionate about his subject matter, so much so that he would think - and this is the extreme - that his allocation of teaching time was 0.1% of what it should have been actually!... And he wasn't seeing this as outrageous... He just thought that because... he was passionate that every medical student should also be equally as passionate and as competent which is unrealistic - isn't it?... I guess that's been the problem all the way through. The politics of medical education has been you know "I mustn't let go of that lecture, or that half hour even, because that in some way dilutes me as an academic".

During his tenure as academic Dean, Professor Samuel often felt he was working against the best interests of the School he had served loyally for over 20 years, by advocating some of the reforms. Nonetheless he acknowledged that the content of the medical program had "evolved" over the previous 25 years, largely reflecting available faculty expertise. But now he was being asked to dismantle programs that had taken years to build:

> The evolution of the curriculum in those *laissez faire* days I suppose was that if you wanted to teach more you could - there was no limit on it effectively and they would argue well 'to do the limb we need three weeks' and so it built up and then once the edifices are built and once the boundaries are there its hard to break them down.

Many of the proposed solutions were particularly difficult to execute. The Anatomy department, for instance, had occupied a principal place in the curriculum over the years and the criticism leveled by the AMC was that contact hours in anatomy had become excessive for an undergraduate medical degree program. Reforming this part of the program proved a major challenge:

> Change depends on pressures and because there were a lot of pressures on us we had to be fairly ruthless in the end and we upset a lot of people... To give you an example, when I first went to the pre-clinical school there was 17 people in anatomy – can you believe that? CB was the original Dean and an anatomist you see...so not surprisingly that was a fairly big department... I'm not suggesting it was all done for self aggrandizement or anything like that, it was just that in those days... there were formulas for staffing and so not surprisingly the more students you had the more actual contact hours you had. It wasn't student numbers, it was contact hours and things like 'equivalent full time student units' and all those sorts of things. It's all formula so if you can increase the formula you can increase your staff. Increase your staff, you increase your status and your research and so on. All those people were appointed, under contract and you can't say suddenly we're going to reduce anatomy teaching by 75% without putting 75% of the staff under threat.

Under Siege from Without

Professor Samuel shared Professor Dixon's concerns at the time as their appointments overlapped. He too felt as if he was fighting for the School's survival and spoke of the significance of the AMC report as critical to the School's future:

> We were fighting for our existence... It may have been paranoid but we felt at the time that people were trying to pull the rug from under the Medical School... and this was another way that it might happen if we got a very bad report and they closed us which they wanted to do in those days.

Everything he wrote he carefully scrutinized for fear any submission he would make at that time would compromise the School in any way. A piece of correspondence I had retrieved from the Archive Office and showed him during our meeting brought a smile to his face as he recalled how he deliberated for hours over the writing of that particular memo:

> Everything you put down on paper in those days was analyzed most critically by everybody and even a wrong word that was ambiguous might let the side down because you'd said something that may be interpreted as being adverse... We were trying to... maintain our Medical School.

Added to that concern was his own ambivalence about the reforms being recommended by the AMC, some of which many of his colleagues felt represented change "for its own sake". He wondered whether complying with the AMC recommendations would in fact ultimately diminish the quality of the graduates:

> I had this conflict personally about what I thought was good and what was being required of us [by the AMC] to bring us into the modern era and whether

> it was change for change's sake... or whether in changing we were going to in fact water down or in some way produce a graduate who was not up to what was the perceived high standard.

He also recalls in vivid detail many of the interstate meetings he was called upon to attend in his capacity as Academic Dean. He recalled one such meeting in particular when he felt he was under siege and being ambushed by Deans from other larger Australian Medical Schools:

> I will give you a sort of a recollection of a meeting I went to in Melbourne with all the [Australian Medical School] Deans and they were all there... because it was to do with the curriculum so it was my role in a sense and when I got to the meeting there were all these people at the table and I remember it well... It was Bill who I'm not sure if he was in the Chair or not but he said to me 'Give me three reasons why the Medical School in Southern State should not be closed"... You see I was challenged to argue for the continuation of the Medical School and all these other faces looked at me intently...I can't remember what I said but you know it just indicated what the feeling at that time was – "We've got to get rid of Southern State Medical School"... You know all the guns were pointed at us and we were fighting for our very lives in those years.

This fight for survival he felt extended to the political front at home. Although few of the local State politicians wanted to see the medical school close "on their watch", he was nonetheless wary of how the local political tide might turn:

> That meeting with the other Deans...highlighted the feeling of the rest of the Australian Medical community towards the school... They were incredibly low periods because that was real, it was a real threat, it [The Medical School] could go and you know all the rational arguments can be thrown out the window... Suddenly the politics takes over - had it been politically expedient at that time to close the Medical School.

Professor Samuels' struggle to defend the school against its opponents extended to the wider University academic community. What he found difficult to comprehend at times were the disparaging sentiments expressed by some staff from other Schools and Faculties about the Medical school and its perceived expenditure of a greater share of limited University resources:

> You were all the time looking over your shoulder and fighting battles you weren't altogether equipped to fight - the political battles and the financial battles - and of course at that time in the University there was not much support for the Medical School. The rest of the University... perceived that Medicine got more than its share... and so other Faculties in the University were almost gleeful that we were under threat and I found that difficult... They were fairly difficult and low periods.

Looking back he sums up his time as Academic Dean as a time when he found himself frequently overwhelmed by the task of implementing reform and inexperienced in matters of pedagogy:

> We didn't throw out the old course. We tried to keep the good bits of it but we went through the process which... was traumatic, it was difficult and we weren't skilled in these sorts of things you know. We were ordinary medical academics, not skilled in educational reform... Suddenly we were involved in debating the issues of student selection, of the process of medical education and always under the threat of closure if we didn't get it right.

Although Professor Samuel believed that school accreditation had become a politically driven process to manage the increasing and costly numbers of medical graduates, he knew he couldn't escape the imperative to comply with the accreditation process in the interest of the School. There was no escaping the continual pressure to change:

> No matter how well you argued about what we had... according to the professional, educational and indeed community perception – [the School] was wrong in the context of the evolution of education generally, not just medical education... so now we struggle with all these educational techniques that you have to justify... You have to assess everything you do, have to change everything you do in the light of assessment, have to be conscious of... 'stakeholders', you have to be conscious of community attitude because they're paying the money.

Yet despite all this, like his predecessors, Professor Samuel recalls with pride seeing his students go on to achieve within the medical profession. This is what kept him motivated to fight for the School:

> The quality of the students, the respect in which I held the students on the whole and hopefully they held me - they were the huge rewards and to see our graduates successful in the world scene - they're the highs... "So and so - did you hear he's got the chair of somewhere?"... We don't hear many of those but you do hear a few...I found that an enormous value and I think that's the reason why you fight for your Medical School because you're fighting for the students who you know are the best in the world really.

Dean (1994-1996) (revisited)

Under Siege from Within

Professor Adams spent most of his two-year tenure as Dean dealing with resistance from within the medical profession as he too tried to introduce change. He had grown frustrated with what he perceived to be failed attempts on the part of the School at incremental reform. During his tenure he wanted to really impress the AMC with a truly integrated curriculum. He began his term in office trying to convince his colleagues of the virtue of combining several of the large disciplines which had hitherto stood as independent silos. He had not foreseen the extent of the hostility he would encounter:

> So we came up with the idea of... Medicine, Surgery, and Psychiatry - all together - under one head, the idea of this was that... we would then have more control over not only financial issues but also curriculum issues...and what we had to do I felt was to firstly try and get rid of the domination of one specialty in final exams and in some way or other to not so much downgrade the importance of final exams but to put them in a context with the whole course. So the first thing we came up with was to have an integrated final exam...but then of course [some colleagues] saw this as a great downgrading of [their] discipline and they started a campaign against anything we did... The Vice Chancellor... said he thought that University politics were dirty but he didn't understand how dirty medical politics were.

Professor Adams paid a big price for leading such a curriculum reform campaign and he found himself at the centre of much controversy. At one high profile meeting with the AMC he recalls being the subject of an overt attempt at sabotage by some of his own colleagues:

> We were starting to send in documentation to the AMC and at one of the AMC meetings [a colleague] had sent letters... complaining about me... An article from *The Mercury* was presented on each [member's] place on the table... We were working from behind the eight ball in a very difficult situation.

Medical School Board meetings became scenes of disruptive and antagonistic disagreement. Colleagues who had recently joined in praise of his new appointment to Dean he felt were now turning against him as he tried to introduce significant reform. He recalls several meetings in which he felt betrayed and under attack from colleagues within the medical school, the profession and in particular the specialist Colleges:

> I felt under siege and I felt quite betrayed by [my colleagues]... Then there was a direct siege from some of the College people and there were other sieges which were different, they were people who wanted only their thing like the

> Professor... who... could never act with the good of the school in mind... He had a stranglehold because we were getting so much research money [from his area] that one couldn't insult him too much... The biggest problem I think really overall was there was so many people who really could *not* see the greater good of the school over their own particular needs or wishes.

During his short tenure as Dean, Professor Adams endured many "low points" including the loss of personal friendships over his accepting the post of Dean in the first place. The most devastating were the events of the morning when he woke to read the front page of the local newspaper, *The Mercury*, which ran a story entitled "Medical School Crisis Worsens":

> The dark shadow over the future of the Southern State Medical School deepened last night with the shock revelation that the school's administration and operation has been strongly criticised by the powerful Royal Australasian College... The college passed a motion of no confidence last week in the Executive Dean of the School of Health Science and Head of the School of Medicine.
>
> *(The Mercury*, 9th June 1996)

The main criticism articulated in the report related to the amalgamation of the departments of medicine, surgery and psychiatry into a department of Clinical Sciences. Although the article went on to say that the University Council's executive committee had, in a subsequent meeting, passed a motion of *confidence* in Professor Adams, he felt the damage to his position had already been done. In his busy professional rooms almost a decade later it is clear that the wound caused by that vote of no confidence is still felt:

> A low point I suppose really was when the College... which really wasn't really the College... it was just a rump of them... met and declared a vote of no confidence in me and then published this in *The Mercury*.

Securing accreditation of the medical school was a personal high point in Professor Adams' two years as Dean and yet despite this achievement he recalls receiving little formal recognition:

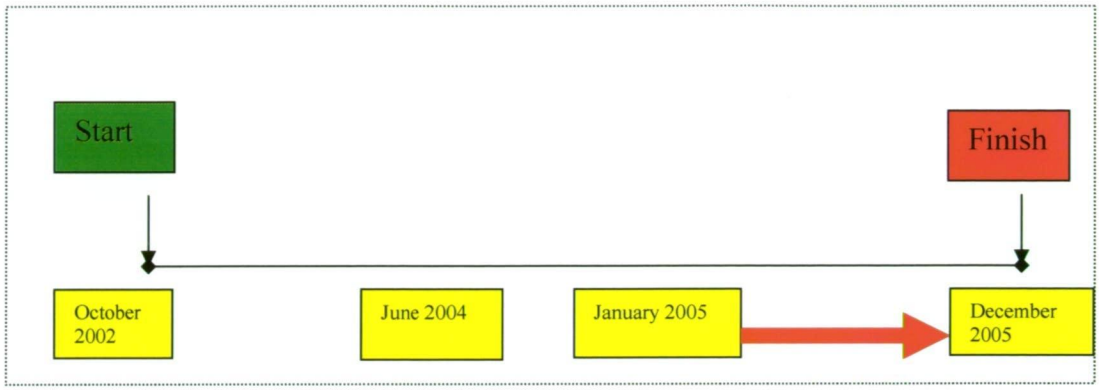
Summary

All of SoM's former Deans had experienced a myriad of issues in trying to accommodate the requirements of ongoing accreditation by the AMC. They faced the threat of potential closure of the medical school and perceived lack of support from Deans from other Australian Medical Schools; they experienced the difficulties associated with trying to operationalize reforms from a poor resource base, they faced a dearth of evidence to support the recommended new educational reforms in contrast to significant evidence to support the status quo; they faced criticism that the proposed reforms represented change " for its own sake" and some felt they lacked appropriate skill in educational reform matters. In one case a vote of "no confidence" in the leadership of the School was expressed by senior members of the profession in response to the controversial decision taken to combine several large disciplines in order to achieve better curriculum integration.

The Deans had each tried in their own way to convince colleagues of the need for change, recognizing the consequences of failing to comply with the recommendations of the accrediting body. In some cases this meant acceptance of incremental change instead of pursuing the more difficult radical reforms necessary. In the one case where radical reform was attempted, the personal consequences were destructive and demoralizing.

As I listen to the stories from past Deans, there are many strong parallels. My own experience of being under siege had also culminated in actions by some members of the curriculum planning team which were interpreted as "no confidence" in my leadership although for different reasons. In trying to translate the "vision" for the new curriculum and propose manageable change which engaged the greatest number of staff from within SoM, I faced criticism by some members of team that I was trying to dilute the original vision for the new curriculum. As a planning group, we too experienced continual uncertainty regarding the School's capacity to resource the new curriculum. Added to this, we were operating in a particularly adverse political climate with some doctors threatening to withdraw altogether their support for the medical school.

Chapter 9 – Race to the Finish



This chapter traces the period from January 2005 until the handing down of the AMC's findings in December that same year. During this time, the final 150-page submission was dispatched to the AMC; a "mock" accreditation visit took place; the external and independent review of resources concluded their report on the cost of medical education in the State and in May 2005 the week-long accreditation visit to the School occurred. It was to be a further six months before the AMC handed down its final verdict, which would determine the future of the new curriculum and indeed medical education at Southern State Medical School.

A Quiet Send-Off

I spent the summer vacation in 2004/2005 editing the substantial final Stage 2 submission to the AMC. With its two dozen appendices this document represented over two years of work. I carefully read and re-read each page, painstakingly ensuring the integrity of every section. I double-checked every standard had been sufficiently addressed, ensuring we had not failed to mention some particular aspect that might have a bearing on our capacity to deliver a sound medical curriculum, nor over-committed ourselves to a course of action we could neither implement nor sustain in the long term.

Once the final edits were made and the document was printed bearing the University logo, it had the external appearance of any ordinary submission. Although it contained

our latest and best laid plans for a shorter revitalized medical curriculum at my Alma Mater I reflected at the time how this detailed written submission still failed to bear witness to the hundreds of hours spent in meetings, workshops and forums. There was no trace in this document of the many trials and tribulations nor the standoffs and resignations that had led to this submission.

Quietly sipping a toast from plastic cups in a corner of the MEU office, the last people to see the final document before it was dispatched to the AMC office in Canberra (again on the quietest month of the academic year) were the project officers of the MEU, who by now, along with myself, knew each section of the submission, "chapter and verse".

The Trial Visit

We resumed our planning meetings in February 2005 with our sights no longer on written submissions, but on the decisive visit by the AMC in May. Following a thorough reading of the submission during the next three months, a team of eight professors from medical schools around Australia and New Zealand would arrive at Southern State Medical School and conduct a detailed analysis of our plans, meeting with staff and students from the Medical School and the local teaching Hospitals. Although we would be given the opportunity to make representations in person, the team reserved the right to call upon anyone whom they felt would attest to our state of readiness to deliver the new curriculum six months later.

Before the actual visit, we had the planned "Trial Visit" to look forward to. I felt we still had large pockets of misinformation and in some cases overt opposition to the new curriculum within and outside the School. The local medical community remained preoccupied with workforce issues and regarded the new curriculum and the impending visit by the AMC as a major distraction. I felt the Trial visit would allow us to identify those who wished to use the actual visit in May as a forum for personal political gain, but would also allow me to identify where to direct our communication strategy in the lead up to the real visit. Now all I could see was the end goal looming. In three months the visit would be over and the fate of the new curriculum would be known. I had learnt to trust my instinct and judgment when it came to making new appointments. In the lead

up to the AMC visit in 2005, our five theme coordinators were a surgeon, a pathologist, a physician, an ethicist and a clinical psychologist, representing in my mind the key domains of the competent, knowledgeable, ethical and collaborative medical practitioner. These five champions were also selected by me for their capacity to work effectively with each other, with others on the NCWG and with their colleagues in the medical school. With the events of October behind me, I felt this was a time for me to show decisive and strong leadership. I was also beginning to feel excited about the months ahead.

Movable Goal Posts and a Final Resignation

A two-day conference in Canberra on Medical Education in March 2005, the title of which was "Shared Vision; Common Goals"(CDAMS& AMC, 2005) was the first opportunity I had in months to escape what seemed to me never-ending pessimism and to meet other medical educationalists who were battling the same reform issues around Australia and New Zealand. This was a defining event for me. It was the first time I had travelled to a national meeting as a (recently promoted) Associate Professor and Director of Medical Education. I could now talk confidently of what it had been like for me personally and for us as a group, developing a new medical curriculum in the past two and a half years.

I felt I had earned this badge of honour and was no longer speaking a "text book account" of curriculum reform, but one based on personal experience. The more I spoke with other Medical Educators, the more reaffirmed I was in the approach we had taken. A number of my counterparts in other Australian States had heard anecdotally of our efforts at reform in Southern State against difficult odds and I was flattered. With medical educators from around the nation as well as some international visitors, many of the conversations at that conference focused on the best ways to achieve curriculum change: incremental, evolutionary or revolutionary change. However, none of the debate focused on how this change, regardless of its extent or rate, impacted on the lives of those tasked with defining, championing or implementing reforms. It occurred to me at that conference we all spoke of "curriculum change" as if it were inevitable, inherently good and relatively painless:

> My exchanges with other medical educators around Australia suggest that the direction that we are taking is appropriate, and importantly all the challenges we face have been experienced by other medical schools around the nation... This is for me quite comforting... The conference did not appear to capture the very real and human face of change as it is played out in the day-to-day activities of medical academics struggling to meet with competing demands on their time... Many of the drivers of change it seems are external and most agreed at today's conference that the single most significant external driver of change was the accreditation process.
>
> Personal Journal 7th March 2005

As I was leaving the conference, one of the participants, whose school had recently undergone accreditation, whispered some parting advice: "Don't be worried about the accreditation visit, you will get it all right - what you ought to be worried about is what you are going to do when you actually get it!" I felt a sudden paroxysm of apprehension. The goal posts had suddenly shifted again. In an instant I was transported to 2007, considering how we would sustain the new curriculum, year after year, with its escalating student numbers[32] and its heavy emphasis on small group teaching and comprehensive assessment plans.

By late March the NCWG group now numbered close to 20 (including student representatives) with a core group of 15 attending meetings regularly. Chairing meetings continued to be a challenging but exciting task. My desire to link in the two clinical schools in the north and the northwest meant the added complication of a teleconference and later videoconference. I felt sure the AMC would take a particular interest in these sites as supporting a distributed model of medical education was known to provide a series of unique challenges for medical schools. We had diligently maintained a state-wide focus in developing the new curriculum and it was important this be continued. One of the key challenges we faced, and one which I felt confident we were addressing, was maintaining consistency in the curriculum across all sites. Nonetheless keeping this large group of academics engaged and communicating with each other on a regular basis in the lead up to the visit was my key mission, as well as fostering an atmosphere at our

[32] In order to compensate staff for the lack of a "gap" year and so as not to overwhelm the clinical placements, the proposed intake for the first year of the new curriculum in 2006 was reduced to 50 students. However, it was understood that steady state would be reached the year after with intakes in excess of 110.

meetings that encouraged focused and productive discussion and problem solving. Knowing we would all stand before a more critical panel in two months, we recognized that last minute decisions now needed to be made quickly and communicated effectively. Absence from these meetings had weighty consequences and attendance during this time was high. We also recognized that we needed to become familiar with the entire curriculum plans as well as our own particular areas. The fortnightly discussions were noisy and animated but enjoyable, and seemed to me a fitting way to use the medical school's only Board Room (now the only room in the building with a big enough table).

The SWCSWG was making remarkably good progress in my opinion, under the chairmanship of the newly appointed Northern Clinical School's Director. Their planning and development focused on the last two years of the curriculum and as we had all adopted the same exit outcomes grouped under the same five themes and shared our vision for assessment, I felt I had no cause for concern on that front.

A series of internationally recognized medical educators visited Southern State at my invitation during 2005, supporting our now regular Medical Education Seminar program and a series of internally produced (MEU) staff development resources meant our staff development website was in particularly good shape for the May visit. Overall, I found the level of activity surrounding the MEU and the NCWG in March and April 2005 motivating and inspiring.

This optimism and excitement was still not widespread though, and it worried me that less than two months away from the real visit, many staff in the Sandy Cove campus remained seriously disgruntled about the new curriculum. Although several NCWG members and MEU staff including myself were spending significant amounts of time at Sandy Cove and four of the newly appointed Unit Coordinators were from this campus, this seemed to be doing little to address the concerns which remained focused on increasing student numbers and the absence of a gap year. There were now rumours that the commitment to a "half year intake" was slowly being eroded as it became apparent that a yet ill-defined number of students from the existing course were requesting

transfer to the new program the following year. Some estimates looked as though close to 100 students could be enrolling in the new program in 2006, instead of the predicted 50. With available teaching spaces already being used to capacity, some staff felt this was completely unsustainable. My personal viewpoint was that these decisions were legitimately being modified in response to new and emerging information and it mattered little whether we were commencing with 100 students or 50, we would still need a world-class curriculum and a commitment to deliver the necessary resources. Others, however, were not so accepting of these continually moving goal posts.

One of our critical unit coordinators felt personally deceived by these developments and tendered his resignation several weeks before the scheduled trial AMC visit. At this point I felt I could not take another "shock resignation", and nor did I think the group could support another serious upheaval this close to the visit. He had been an integral member of the group of four unit coordinators and he was well liked for his experience and "student-centeredness", and for his capacity to translate the new curriculum "vision" into workable timetables for the first year students. However, with the AMC trial visit just around the corner, I could ill-afford to lose another team member. I encouraged a meeting with the Head of School to try to negotiate a withdrawal of the resignation or at the very least a delay. By the end of the meeting I was pleased we had at least achieved the latter but not without my having had to endure another tirade of pent up disgruntlement over the new curriculum and over proposed growing student numbers. For once these issues were aimed not at me directly, but at the Head of School. I sympathized with his concerns but I nonetheless felt (on the basis of recent experience) that at this stage the project was greater than the individuals and the School stood at the brink of a bright new future. In two months we would have endured the worst, and with the AMC's seal of approval on our new medical program we would be in a stronger position to begin a targeted staff recruitment campaign branding ourselves as a new revitalized integrated curriculum. Nevertheless, I felt the project was paying a very high price, for we were losing the support of too many good and loyal academics and I felt I could not manage emotionally the impact of any further resignations during my tenure as Chair of the NCWG:

> Xavier gave e-mail notice today of intention to resign. This has sent shock waves through the rest of the curriculum working group. He was a key player... and critical to the rollout phase for [the first unit]... Arranged to meet and discuss his rationale for resigning. I cannot manage, I feel, any further resignations, first the loss of Jacinta, then followed the loss of Harry, followed 12 months later by Jonathon and Brian, and now Xavier... It seems as if this whole project is fraught with discontent and a series of consecutive resignations... I feel as if the project itself and my management of it is becoming a scapegoat for those who feel as if the 'institution' has somehow let them down.
>
> Personal Journal 17th March 2005

By the end of April I had thankfully secured a commitment from the same unit coordinator to remain until after the Trial visit and possibly the May visit but that should we find a replacement before then "he would happily stand aside". Once again, I found myself embroiled in continual "brinkmanship" over the new curriculum. It was taking all of my best efforts to recruit a solid team around me. It seemed that some members, once inside the group, wanted to use the planning process and their participation in it for political ends and to voice dissatisfaction with a system that was seen to have somehow failed them. Although I could see their point of view, I had by now grown intolerant of the distracting political games that were being played. The only result I was interested in now was a fully accredited medical curriculum for SoM.

An Enthusiastic "Trial" Performance

The AMC Trial visit went ahead as planned in late April 2005. It ran over three and a half days with close to 300 PowerPoint slides prepared in support of the submission. Morale in the NCWG on the day was excellent and everyone presented their material enthusiastically, although sometimes nervously. I sat back after my own presentation and listened with enormous satisfaction as each member of the team took the lectern in succession and spoke passionately about all aspects of the new curriculum, from student selection matters, to the defined exit outcomes of the curriculum (the MGP) to our carefully crafted assessment plans linked to the curriculum objectives. I even thought I saw a glimpse of pride in the presentation our outgoing unit coordinator delivered on the first module of the new curriculum to the assembled audience, and for a moment wondered whether he might reconsider his resignation.

Presentations went well overtime but the panel was lenient, for everyone seemed to want to take the time to explain their part of the new course and how it would all fit together. This was a forum in which we all felt we could make a mistake without being penalized for it. In fact it was better to make the error now than in front of the panel of seven in a month's time. This was the most enthusiastic performance I had ever seen the NCWG or the Theme Coordinators deliver and I was confident we were as prepared as we possibly could be for May.

One Final Compromise

Overall, the feedback we received from the trial visit panel was helpful and encouraging. The introduction to their report on findings read as follows:

> The School has achieved an enormous amount in the past two years in relation to the conceptual basis and development of the new curriculum. Highlights of this development have been a clear work plan, wise use of consultants, strategic appointments in medical education, extensive liaison with the profession and most importantly assistance and support from the Federal and State Health Departments... The MEU is playing a critically important role in coordinating change.
>
> Brief Report on Southern State Trial Accreditation Visit April 2005

Suggestions about the visit program included the need for shorter "information giving" sessions, allowing more time for questions at the end of each session, and limiting uninvited contributions, however well intentioned, from members of the audience. However, the most significant suggestion regarding the curriculum was less straightforward. The considered view of the two-member panel, both experienced educators, was that we needed to rationalize our plans for student assessment, which they felt were too ambitious. They had quickly identified we were a school with limited numbers of academic staff and that our design and "roll out" of the curriculum, together with assessment and evaluation planning, was going to be an "enormous task". Their Report went on to say: "On top of this there is going to be teaching in the old and new courses at the same time as the development of new materials for the [new] units" (Simpson & Kirkby, 2005 p.2). Nonetheless they commended our achievement in terms

of clearly articulated curriculum outcomes and a clear curriculum mission and soundly conceived teaching and learning strategies:

> The philosophy is of a learner-centered curriculum with the outcomes for student learning clearly enunciated and used to determine emphasis and content. The School has clearly described the mode of delivery of the curriculum, which is centered on Case-Based Learning in each of the 5 years of the course as well as the usual clinical activities, lectures and tutorials... The basic principle of assessment of each of the five themes in an integrated examination format is well conceived. However the draft assessment schedule in years 1 and 2 lacks important detail (e.g. weights, number of questions) and appears excessive... There is a need for discussion and rationalization of assessments to provide an appropriate mix of barriers, summative assessments, formative assessments and remediation pathways and for these to be clearly distinguished concepts. In addition the implications for staff time required to produce a volume of assessment material were discussed only in impressionistic terms. Further rehearsal of questions and answers regarding assessment would be valuable prior to the AMC visit. (p. 2)

I knew our immediate task then was to return to the drawing board to see what formative or summative assessment plans could be deleted. In particular we would have to revisit the student portfolio, whose annual marking load was set to consume significant staff hours. This was a difficult exercise for me, for I felt it represented a significant departure from the original vision for the curriculum. Robust assessment plans were at the heart of the new course and so I reminded the NCWG we were under no obligation to accept this advice. Nonetheless I felt torn. To ignore this advice might undermine everything we had worked so hard to achieve. With a month to go there was no time to hesitate.

A hastily convened group of us met in the library for a day and in record time we overhauled the assessment plans for the new curriculum. Simon was nominated as the spokesperson for all matters relating to Assessment in May (although I had chaired the Working Group) for I recognized my lack of commitment might well betray the team on the day. He was the pragmatist in the group and was possibly the more convincing. These modified plans were taken to an extraordinary meeting of the MEC. Not in two years had I seen the NCWG or MEC respond so promptly. What lay in the balance was accreditation of the new curriculum and everyone was pulling together to give SoM the best possible chance.

In the month before the actual visit the focus of the group's activity was around things we could realistically amend in the remaining time. As we read and re-read the Trial Visit Report the mood in the NCWG seemed to oscillate between feeling genuinely positive and totally defeated. In addition to the suggestion to amend our plans for assessment, several additional items of information were identified as being essential before the AMC visit. One of these related to the first unit of study:

> There is a need to demonstrate that the school is ready to move from the curriculum plan to its full implementation. In particular, one or two cases from CAM 101 need to be available in their entirety including any web based supporting materials online for review by the AMC visitors (p.3).

Our dilemma, however, was that our very first unit (CAM 101) had lost its development coordinator and the other coordinators, whose work followed his, were keen to know who his replacement was going to be. I had no answers. The emails I received from NCWG members revealed mounting frustration. One particular note read: "I have grave reservations that any credible work can be done between now and the 16th [May] that would lead the AMC to believe that we can roll out a typical week [in first semester] – let alone 13 of them". I refused to accept that this was the case and all I could reasonably do by way of response was to indicate how hard everybody else was working on the project to "make it happen" and mobilize resources to the help him in this task. An excerpt from my hopeful response read as follows:

> Thanks XP
> All sorts of miracles happening at the moment... The Themes Task Group have met to plan their presentations this morning and are confident, the Research Task group... is looking very positive, as you know the Assessment Task Group is in reasonable shape to answer the queries that are likely to be posed... has recruited 12 GPs already!! ... Once we clarify Xavier's intentions I'm sure we can make this happen to all of our credit. I'll talk some more...
>
> Email dated May 2005

My own reflections at the time highlighted my concern that we were going to see yet another resignation. Although this never transpired (in fact this coordinator went on to

make a lasting contribution to the new curriculum), nonetheless it seemed we were all experiencing a lot of anxiety during the last few weeks in the lead up to May 2005:

> Two weeks to the AMC visit and everyone is feeling tired and anxious...Another sobering e-mail from a UDC [Unit Coordinator] who is becoming weary and likely to step down in due course... There is no doubt this is a very trying time at present and everyone's perspective oscillates between "can-do" and "this is impossible!"... I have been to so many discussions and meetings lately to try and keep everyone focused on the fact that we have spent two years producing a very deliverable product; we just need to convince ourselves and the Australian Medical Council. I believe we as a school deserve a chance to rollout this new innovative course and I believe firmly that it's now or never. Another month, six months or six years would make very little difference to us now.
>
> Personal Journal May 2005

The Week of Reckoning Arrives

Everyone agreed not to take holiday leave between the 16th and the 21st May 2005. The relevant hospital and Department of Health officials were advised of the dates months in advance and they had all received a personal briefing by myself or the Dean. There was much to consider in planning the itinerary. I had to anticipate who the team was likely to want to meet in addition to the scheduled presenters. The Vice Chancellor himself was critical to the review but he was due to fly interstate later that week. After several iterations the final schedule was circulated. All I could do now was hope the local political issues at the teaching hospital would remain subdued for the duration of the visit and that no-one would be tempted to use the visit for political ends.

The morning of the first day got off to a good start. The team of seven, consisting of mainly Deans or Executive Deans of Medical Schools around Australia and New Zealand, was disarming and friendly. A few members of senior Executive met with the team in the Dean's office and after I explained the program we proceeded to the Board Room. The Chair of the team made it clear he was new to this role and thanked us for the impressive submission and expressed how delighted he was to lead the team and how he looked forward to an informative week ahead. In the Board Room the first of the series of PowerPoint presentations was ready, the curtains drawn and the relevant

presenters standing by the lectern with glasses of water at hand. Only those who were required to be present were permitted into the Board Room and the entire program remained on schedule.

As the first day rolled on, it became apparent that the experience of the Trial visit had stood us in good stead. The team was professional and friendly. They each took it in turn to pose questions to each presenter, which had clearly been rehearsed. All of the questions were reasonable, if not somewhat predictable. Issues that emerged during their week-long visit were all the sorts of things that had arisen at the trial visit. I watched carefully the expressions on the faces of each of the panel members as they quizzed us, looking for any give away signs. Hour after hour they listened carefully to our presentations, greeting the new members who joined each session, taking copious notes and posing carefully considered questions in turn to each presenter. I stayed in support of every presentation and was confident they had read every line of our written submission. Outside the Board Room a few staff lingered to receive feedback on how they had gone and all I could say was "come back on Friday morning", when they would read out their preliminary findings. For part of the week-long visit the team divided itself between the two clinical schools and site visits to the Vice Chancellor, the hospitals and Sandy Cove. I went to as many of these as I could and was particularly impressed by the visit to Northern Clinical School. As I sat quietly in the back row I could see how committed and passionate this team was about its work refining the last two years of the existing program. We had been working in opposite ends of the island for the past two years and I knew that the Northern Clinical School Director and her team had worked tirelessly. Their thinking and planning was closely aligned with the NCWG and this showed in their presentations to the team. The shared vision for the new curriculum had been communicated clearly in the end, I felt, and translated appropriately in each of the three clinical schools.

I was mentally exhausted by the time the after the week-long visit was concluded.

The Preliminary Findings

Finally, the last day. This was the point at which the panel would hand down its preliminary findings. The agreed plan was that we would all assemble in the main lecture theatre at 9:30am sharp and the panel Chair would read out the findings. Everyone in the School had been briefed by email *not* to pose any questions for they were not permitted to expand beyond the statement of findings, which they themselves pointed out were not binding. The final recommendations regarding accreditation could only come from the Accreditation Committee of the AMC and this would take some months before the final response would reach the School.

It was a solemn gathering in the lecture theatre that Friday morning. When we were all assembled, I was embarrassed to realize the panel members outnumbered the audience, leading to the suggestion we all move to the front row of the large lecture theatre. I looked around to find the others on the NCWG, but could see only two, and then I remembered it was scheduled teaching time now and that might account for some of the absentees. I nodded to the Dean to indicate I felt those who were likely to attend were probably already here and then following some paper shuffling, the ten-page document was read aloud by the Chair of the panel.

The report began with the usual thanks to the school for hosting the team and then proceeded to address the AMC standards one at a time. A quickly recognizable pattern emerged: a statement of fact followed by a flattering remark occasionally followed by a recommendation for improvement. I jotted down the points that began with "the Team was concerned that..." or "the Team was pleased to note..." In total I had noted 30 commendations which easily outweighed the dozen or so recommendations. This was surely a good outcome, I thought. We were advised not to "read too much" into the preliminary findings, a copy of which I managed to secure that afternoon. I scrolled quickly down to the section on "Assessment", knowing this to have been traditionally our weakest aspect of curriculum design and was pleased with what I read: "The School is to be commended on the progress it has made in the area of assessment," the document read, pointing to the way in which assessment is "well documented and linked with the integrated and thematic construction of the curriculum" and going on to praise

the "innovative use of portfolio assessment". Although they pointed out some issues relating to reliability and the need for further evidence of Standard Setting in the early years, my reading of this particular standard was that we had probably passed. I could not be certain though of my synopsis and neither could the Dean; nonetheless our feeling was that we had done well and it was more likely than not that we would be starting the new curriculum as planned the following February.

I felt I had come to know the Dean, Professor Phillips, more than most over the course of the two and a half year project. Although he was a very private and somewhat shy man, I felt I could say with confidence he was in high spirits in the weeks following the accreditation visit. As Dean he could have hoped for nothing more. The School had been presented in the best possible light and there had been no last-minute unexpected attempts to sabotage the accreditation process. His memo to staff the next week paid tribute to everyone who had worked so hard to make the new curriculum a reality. A particularly poignant reference to "past and present" members of the NCWG did not go unnoticed:

> I would thank and congratulate all involved in what has been an outstanding and sustained effort to improve the current course and develop the new curriculum. In particular, I would thank the members of the Executive who have led particular areas of the work, the Medical Education Unit and the past and present members of the New Curriculum Working Group, Unit developers and all those who have contributed to Working and Task Groups. While we will not know the final recommendations from MedSAC and the AMC for some time, I believe the findings to date present a very positive outlook for the School.
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> Memorandum to all Staff 23 May 2005

Patience is a Virtue

Professor Phillips was quietly confident that we had been successful following the May 2005 visit and felt vindicated in having recommended the major reform of the curriculum four years previously:

> I'd have to say I'm very pleased where we are at the moment I think... to have got to the point where the accreditation team and hopefully AMC have

> acknowledged where we've got to... The recommendations are very positive, I think, and that's due to the work of a lot of people but I think it probably confirms that we're on the right track... I think there's a general acceptance in the community now of the change, [although] there's still some apprehension about how that might be delivered.

Like many of his predecessors, Professor Phillips openly acknowledged he had not been fully prepared for the role he would play in medical education:

> When I came here as Professor of Paediatrics and Child Health, I ... had a focus particularly in that role and in building up that discipline... I had probably no major understanding of curriculum development.

Nonetheless the decision to recommend the development of a 5-year curriculum was the culmination of many years' deliberating over curriculum matters. By the time he arrived in 1987, the school had undergone its first accreditation visit, which as he described "had posed a whole lot of problems". A period of limited accreditation followed and a "process was put in place to reform the curriculum" such as reducing "over didactic teaching styles" and managing "excessive content" as well as some specific deficiencies in individual areas like communication skills teaching:

> An education committee was set up at the time, chaired by an external consultant, which was to become the precursor of the current Medical Education Committee, charged with undertaking a review of the perceived deficiencies. A limited and superficial examination of curriculum occurred in the early 90s with the course remaining largely unchanged. The view taken at the time was to decrease the amount of material for each discipline by 25 percent, the overall result being...not much real integration as a result.

Despite what he viewed then as a shallow attempt at reform, the School managed to secure an extension of accreditation, following which the process then lapsed, according to Professor Phillips "in terms of at least the vigilance on seeing that the developments were proceeding" and the AMC became subsequently concerned that "the wheels had [again] fallen off". It was at this time that Professor Phillips took over as Head of School in an acting capacity in 1997, a time at which he recalls the School needed to consider "fairly major curriculum reform":

> The evidence was that the previous attempted reform really hadn't worked and there were a number of impediments which were such that it probably wasn't going to work.

Despite the efforts that followed the School went on to suffer a disappointing result again in 2001, following the visit by the AMC. He attributed this result to the School failing to present a unified voice of commitment to reform:

> I was very disappointed in the 2001 outcome and again there were some examples I think there of people shooting us in the foot – themselves, but the school also, which we've now got over.

There were a number of other changes in the national landscape at that time, such as other Australian medical schools moving to graduate medical programs and the nearest neighboring Australian medical school foreshadowing that it might go to a five-year program. Changes in the hospital training requirements of junior doctors with greater precision about what was required in terms of educating junior doctors were other factors impacting on the decision he took at that time:

> So a number of those factors coming together certainly led me to believe that a five-year curriculum was the way to go and it had the added component that we would be at least in a more competitive situation.

Professor Phillips's vision for the new program was based on his perceived need for better integration:

> I certainly became aware and I guess I was aware much earlier in the 90s that we needed an integrated curriculum. At one stage... we'd have lectures on haematemesis, one given by medicine and one given by surgery...as an example of how unintegrated and how incomprehensible to students that must be.

It took five years between taking over as the Head of School before the School's decision to progress with a five-year curriculum was passed and officially endorsed by the AMC and a further three years before the new curriculum was to commence. In all, he was to wait patiently, acting, as he described, "with a fair bit of persistence" for the best part of a decade, before he himself was to realize major curriculum reform, admitting he never expected it to take this long:

> With a small size school and resources while it's small and you can do many things it's also small and if two or three people 'dig their toes in' it's very hard to shift... I think the positives have been where we've actually got with the curriculum [but] I think that the downsides have been that it took so long to get there and we had so many ups and downs.

Reflecting on the qualities required to succeed he points to the need for resilience and stamina:

> I guess a fair degree of persistence... You've certainly got to be prepared I think for knock backs in various areas and then try and work around them, but I think the other critical issue, and I think this is where we've been very fortunate, is to be able to appoint people who can carry through things... We've got some very good young people I think who will be capable of further development if we can remove a few inhibiters around them... So I think the ability to be able to appoint a team and then to work with a team to achieve a common end I think is important.

Professor Phillips had engaged everyone around him quietly and determinedly to secure the School's future. Unlike his predecessors, he saw the AMC as an ally and he was grateful for the support he personally received from the Council in introducing reform:

> I think the other things that were influential and have helped us are certainly the AMC's support of the process... They moved from what was perceived (whether in reality or not) as a group who were sort of "out to get" medical schools in the early 1990's - through to a very supportive group, at least in our case, that wanted to work very collaboratively with us.

Process versus Outcome

Simon was not so effusive in his praise of the AMC. He had seen many representations from medical schools to the national accrediting body – including representations from his own school, SoM. Neither did he approve of the way the curriculum reform process was being "driven" by the AMC. To him everything seemed too heavily focused on convincing the panel when the real issue remained how we would implement our proposed plans given our tight fiscal constraints.

He was not convinced that the AMC accreditation process was soundly based:

> As you know I've done a fair bit of work with the AMC... I still think they're obsessed with process rather than outcomes and realistically I really feel we should look more to the American model whereby what the national body does is look at how the doctors turn out... In other words, I don't care how you get there - if you produce graduates who have what I want them to have in knowledge skills and attitudes - I don't care whether you just cram that into them or set 'em free in the wards and say come back in 4 years... Now, that's me... I'm outcome orientated... I would still like to see [the AMC] more involved with outcomes and less involved with process.

For Simon, the end of the project had looked much as he had envisaged at the beginning. He believed he might have achieved the same outcomes more easily and with less disruption to staff, although he accepted that the slow and measured approach we used ultimately secured the requisite level of engagement with staff which he acknowledged the project needed in order to succeed:

> There's a feeling at the end of the day that I could have scratched out what this new curriculum was going to look like on the back of an envelope at the very beginning... Did we really need to go through all of this in order to get there?... I think if you wanted people to accept it 'yes' you did - but at the same time I knew what it was going to look like before we started. Now that may have meant that I've been very successful in making sure that it looked like that - but I don't think I have - for anybody sitting down looking at it would have drawn it this way and why didn't we just do that quickly at the beginning?... So would I have done that differently? No - we probably did need to do what we did... My role in the last couple of years I've seen more as making sure that I feel that what's emerging is realistic and where it became overly ambitious that we try and pare that back.

Uncertain Timing

Following the visit, I now turned my attention to recruitment and staffing the small group learning sessions for 2006, basing my predictions on a maximum number of 100 students. A meeting with the Dean to discuss the critical matter of staffing the new curriculum was scheduled and I was given the green light to launch a recruitment strategy, the only caveat being that we could *not* offer definitive contracts until after the official response from the AMC had been delivered. I began to better understand the precarious timing of the entire project. Resource issues could not be resolved until after the consultants' analysis of staffing requirements had been completed and agreed upon by the key stakeholders (the University and the Department of Health and Human Services), the relevant documentation for which was still working its way through the bureaucracy. Presuming these stakeholders were happy with the content of this report and agreed to add financial support to the school, their decision to do so depended upon successful accreditation by the AMC which would not be known until November. To complicate matters further, final student numbers would not be known until positions were advertised and students of the old course who wished to transfer to the new had sat

end of year examinations and known which year of study they would be eligible to join –and none of this could occur officially until the accreditation status of the new course was known!

The Arrival of the Cavalry

We decided to run another Curriculum Forum in August 2005 to "iron out" last-minute implementation issues and invite the pool of tutors I had recruited and had been coaching for some weeks to meet with the staff from the medical school. These tutors were predominantly General Practitioners with an interest in teaching, many of whom were past graduates of the School. The title given to this last Forum prior to the implementation of the new curriculum was "Forging Ahead with Endurance". A play on the epic voyage of Ernest Shackleton, the title page of the program showed a picture of his ship *"The Endurance"*[33]. It was probably a fitting tribute to all those who had contributed to our epic voyage of curriculum reform, although I did point out that Shackleton's ship never actually completed its journey, although most of the men on board *The Endurance* survived. Perhaps our claim might be that we *did* complete the journey, though not all our men survived!

Of all the Forums this one was for me the most enjoyable. For the first time, close to half of the participants were new – all potential tutors interested in finding out more about the new curriculum. These tutors had heard about the program through the various newsletter articles I had been issuing over the previous months. General Practitioners had not previously made any significant contribution to the medical program in Southern State and so this represented a significant departure from usual practice. These new tutors would need to be initiated into the culture of the Medical School and particularly the culture that prevailed at Sandy Cove where the students of the new curriculum would spend their first two years in the anatomy dissection lab and immersed in the other biomedical sciences. As usual, time was against us, for no definitive offers could be made until after November, but most of the tutors I selected were thankfully happy with

[33] The *Endurance* never completed its journey, having been crushed by ice, but there were several survivors, which was a tribute to the perseverance of Shackleton and his team.

this arrangement as their teaching commitment would merely supplement their clinical practice.

For the time being I put all concerns relating to recruitment behind me and concentrated on the positive ambience that pervaded that final Forum. It was uplifting to be amongst so many enthusiastic staff. I wandered from table to table and watched with pleasure as the small groups, engineered to include a mix of new and existing staff, discussed the details of the proposed first year of the new curriculum week by week. Although there were still many skeptics who regarded this potential increment in staffing as "too little too late", I was personally reassured that the long awaited cavalry, although modest, had indeed arrived.

The accompanying press release in the University newsletter *UniTas* spoke of the "pioneering" new medical curriculum and how the new teaching and learning strategies had been designed to challenge students to "explore their current concepts and develop new ways of thinking". The local Faculty newsletter spoke of the "excellent collegial support" being shown by local medical practitioners who would be involved in delivery of the new 5-year medical degree program" (Healthlinx, November 2005, p.4) and the University newsletter article which reported on the Forum spoke of the challenges of small group teaching:

> Frank Hurley's powerful image of Shackleton's ice-bound ship, *"The Endurance"* has become a theme to inspire the group to tackle the "epic" challenges involved in the completely new style of teaching
> (*UniTas*, August 2005, p.4).

A Costly Report

By October 2005, the long-awaited consultancy on resources was complete. Entitled *"A Study of the Cost of Medical Education at the Southern State Medical School"* the most significant outcome of the report was the prediction that the cost of medical education in the State would increase by 88% from $2.901 million in 2003 to $5.467 million in 2011. The report took into account the increase in student numbers, the proposed delivery modes of the new course (i.e. more small group teaching) and the need for additional

teaching and administrative staff. The Report was welcomed by most stakeholders for its level of detail and the Vice Chancellor spoke of:

> This review of our services has meant that we know we can definitely continue to offer quality medical education and provide a steady stream of qualified health practitioners to Southern State ... We can provide – and we will provide. To highlight our commitment to undergraduate medical education... [The University] and the [Department of Health] have signed a joint Memorandum of Commitment to redefine and make concrete our joint responsibilities.
>
> University Media Release 13th May 2005

This statement of commitment to supporting the Southern State Medical school was indeed good news. The October edition of *TasTalk* ran its regular feature on the medical school and predictably the results of this study featured prominently. I hoped the funds would be released quickly but was not really anticipating a significant increment to teaching staff for the first year of the new course to exceed the dozen GPs I had recently recruited myself. I decided therefore to focus my efforts on immediate training of this small but critical pool of tutors.

The enthusiasm shown by the new tutors was refreshing, with many requesting additional skills in small group teaching. We delivered several modules on these and other aspects of the new curriculum over the following three months and I was also pleased to be able to offer this group access to the newly launched Graduate Certificate in Teaching and Learning for Health Professionals, which I had been contributing to for several months.

A Sound Victory

The much-awaited decision was finally handed down in November. The formal announcement by the Dean on the 28th November was by then really no major surprise but it did allow us to finally make definitive plans for the following year. The confident memorandum from the Dean spoke of the School's final release from a decade of record poor performance against the AMC Standards:

> I am delighted to advise that the Australian Medical Council has accredited the new MBBS course until 31st December 2011 and has granted the current six year

> course accreditation for the same time to cover its teach out. This is an excellent outcome for the School as its accreditation is now subject to standard procedures compared with the stringent conditions and limited periods of accreditation which have been in place over the past ten years... We can now confidently implement the new curriculum in 2006... This will establish the School at the cutting edge of medical education in Australia.

I felt euphoric, recognizing this was a remarkable and historic victory. When I opened my personalized copy of the printed accreditation committee report of December 2005, my eyes were immediately drawn to the front page executive summary which listed amongst the School's notable strengths:

> A particularly strong Medical Education Unit (MEU) which has been a major driver of the new curriculum through excellent vision and leadership.

A series of celebratory media releases followed. The University ran a story entitled "Accreditation Celebration; School of Medicine gets a clean bill of Health". This article spoke of the medical school's "commitment to providing the State with high quality medical training" (University Newsletter, p. 9) and the University Media Release entitled: "New Doctors Faster and Better" spoke of the "unique course which will bring our medical teaching to the top of the line in terms of Australian and international medical education" (Media Release, 30th November 2005).

There were numerous specific references to the work of both the MEU and the NCWG throughout the accreditation report all of which augured well, I hoped, for our continued funding. It was December 2005 and in two short summer months we would finally have the opportunity to put our best laid plans into action. But for now we had succeeded in convincing an independent expert panel of our commitment to medical education reform and our capacity to deliver a world class medical curriculum.

Summary

By January 2005 the final submission had been dispatched to the AMC; a mock accreditation visit took place in April to better prepare all staff for the actual week long

Accreditation visit to the School a month later. It was to be a further six months before the AMC handed down its final verdict, which was hailed as a resounding success story for the school. Following a decade of record poor performance by the School against the AMC standards, the School had now secured accreditation until 2011.
Numerous internal and external factors had threatened to undermine this project from the beginning and these included: lack of commitment by staff to reforming the existing curriculum and reluctance to accept the need for change, marked resistance to change from key senior staff, widespread concern about insufficient resources within the school, an adverse political climate with critical medical workforce shortages, a series of internal critical resignations from the project planning team over perceived compromise to the original vision for the new curriculum, leadership issues and eroded trust in the medical school decision making over commitments to cap increasing student numbers.

By the end of the three-year project, however, I felt the process had been finally vindicated. The project management style I had used to lead and coordinate the curriculum development effort was styled on a participative model. At each step I focused the team on adherence to agreed targets and deadlines using a project management approach. Continual focus on our terms of reference did not allow for time-wasting preoccupation with matters outside our remit, such as resources, particularly in the early phase of the project. The focus by the lean but influential Medical Education Unit on regular staff development initiatives, targeted curriculum evaluation and a transparent and consistent communication strategy conformed to best practice in medical education. Proximity to the Deans office provided for regular communication lines between me, the NCWG and SoM's most senior office holder.

In summary, the process used was soundly based and ultimately the outcome was a success. We had convinced the external accrediting body of our commitment to radical reform and our capacity to deliver a world class medical curriculum.

The consequences of the project, however, were much less clear.

We had lost permanently on this journey of reform the commitment of some diligent, committed and visionary teachers, and there still remained large pockets of uncertainty about the benefit of the new reforms even amongst those who agreed to teach in the new program.

Although the curriculum at SoM was irrevocably altered by our intervention in the past three years it nonetheless felt to me as one who had helped craft it, that the curriculum was nonetheless poised and ready in a moment to "absorb" the effects of the recent reforms and revert back, like Bloom's amoeba, to its traditional form. I sensed that continual and unyielding vigilance was all that stood between the School's new found status and a steady retreat back to the past.

Conclusion – Full Circle

Continuing the Story

Throughout the time frame of this study I have come to think as a narrative inquirer thinks and to recognize the events related to me and experienced by me as happening over time: "each event or thing has a past, present...and implied future" (Clandinin & Rosiek, 2007, p.45). It is therefore apt that I return briefly to the continually changing landscape for a glimpse of the next phase of my story and deliver it, at least through my own lived experience of recent events, recognizing that these final words are delivered without the parallel storylines from my colleagues. Although their pages are blank, it is nonetheless possible to extrapolate to the next potential place on their plotlines, recognizing that that is how we understand the world we live in, not only by reference to the past but also, as Mattingly (2007) points out, by reference to "the possible, to the subjunctive world of 'what ifs'" (p. 410).

February 2007

It is now 15 months since the decision to accredit the new medical curriculum and we are in the midst of delivering the second year of the new program. This month the first year of the new curriculum was "rolled out" for the second time but on this occasion with a full cohort (110) of medical students. The first cohort of 'inaugural' students (a smaller group of 60) is now experiencing the first iteration of the second year. I am the second last remaining member of the original NCWG established four and a half years ago. The group continues to meet regularly to oversee the implementation of the first two and last two years and the development of the third year. We have since recruited others to fill the vacancies created by the academics who separated from the curriculum project. A significant number of the original members left curriculum development matters aside to resume their focus on research, which had been shelved for the benefit of the new curriculum planning project. The MEU office was recently relocated to Sandy Cove to oversee the implementation phase and, whilst this decision was at my own instigation, the lack of proximity to the School executive is proving problematic. I

no longer have the same sense of ease of access to the Dean, and the MEU separation from the main teaching hospital and therefore clinical colleagues has the potential to cause a reversion back to what I felt was an unhealthy separation between the clinical and pre-clinical departments. In addition I feel this physical distance will foster a detachment between the new curriculum currently being delivered in the 'old' campus in Sandy Cove and clinical colleagues all of whom are based in the city centre teaching hospital. I am hopeful the new relocation project will redress this separation. In the interim I am committed to regular visits back to the medical school headquarters and the continued distribution of our newsletter.

The sense of déjà vu in my new office is profound. The office where I now sit to write these closing chapters was once the office of a former Dean and mentor. This second floor office also sits directly over the anatomical dissection room where I began my medical education in 1982. The strong smell of formaldehyde lingers in the stairwells and takes me back to group dissection and the powerful drama that was my first encounter with the human cadaver 25 years ago. From my office window I can hear the animated voices of first year medical students as they congregate outside the lecture hall. I trained at this medical school, returning as a senior academic to coordinate significant curriculum reform; it was a presumptuous act by any account and made the more difficult as many of my own teachers were still present when I commenced my new role. An overpowering sense of "history repeating" has been with me throughout every stage of this project.

As for the new curriculum – it was launched in theatrical style in February 2006 around our first case-based teaching event. With the help of the local ambulance service and paramedics, we staged an emergency response in the large lecture theatre to really impress upon the students that they had arrived to take part in a program quite different from anything that had taken place before. Thankfully we have been able to remain faithful to the weekly small group teaching activities, and the group size (so far) has not exceeded ten students per tutor. The entire group of tutors are clinically trained (either GPs or Nursing qualified) and the students have remarked how much they enjoy the

anecdotes and clinical flavor these teachers bring to the first year of the curriculum. Nonetheless, we are experiencing some "teething problems". Those who have remained ambivalent or opposed to the new program (which includes several members of staff teaching in the new course) take the opportunity to point out that the first year module evaluations do not compare as favourably to results of modules from the old program. I remind the planning team that we need to place the negative aspects of these student evaluations, which focus largely on administrative matters, into context and that many of the issues raised will improve over time. One of my main concerns is the continual change-over of module coordinators and identifying staff who are prepared to take on the role long-term. I am drawn unwillingly into the realm of administration of the new curriculum and resources remain an issue. Despite the promise of more funding, the School's income, it seems, cannot keep pace with the university-wide financial "clawbacks". Several critical staff resignations which had been rumoured for some time have coincided with the commencement of the new curriculum creating several 'difficult to fill' vacancies. Some of my colleagues tell me they are pleased to be part of the new curriculum, particularly the GPs who regard the opportunity to engage with bright young and enthusiastic medical students a privilege. Some who have taught for many years in the old program are less forthcoming. Overall the staff and student evaluations are, from my perspective, acceptable, although understandably there is room for improvement and the ongoing refinements continue. Physical space remains a key concern for staff as the number of students steadily grows. In March 2005 the uncertainty for me was whether the new curriculum would receive full accreditation; in March 2006 the topical issue was whether we would have sufficient staff to teach the new curriculum; and now in March 2007 both staff and space present the biggest threat. We are all anxious to know whether the new medical school building will be capable of accommodating the steady growth in student numbers and the evolving staff needs. Most of the new GP tutors are thoroughly enjoying the small group events and have formed an independent lobby group. I meet with this group weekly in the new MEU office and their enthusiasm is clearly out of pace with some of the long-standing permanent staff. A few of the new tutors are participating in the Graduate Certificate for Teaching and Learning and are continually presenting new educational ideas. They quickly recognize that the teaching spaces allocated to them for the weekly small group events are less than ideal. Fresh requests

are emerging all the time for white boards, Internet access and examination couches to help make these sessions as interactive and clinically focused as possible. I am reminded of the comment by a colleague exactly two years ago: "you will get it, all right'' he said to me as we walked out of the conference hall (referring to the forthcoming SoM accreditation). "What you ought to be worried about is what you are going to do when you actually get it!" Two years later I find some truth in his advice, as one challenge simply replaces another.

Medical student numbers have exceeded the previous year's predictions. Thankfully no-one has suggested we compromise our delivery plans or our innovative (albeit slightly ambitious) assessment plans to accommodate this. The portfolios are slowly stacking up against the wall in the MEU office awaiting marking. Last year through delegation we just managed to sign off on them all. The reflective writing by first year students was particularly heartening to read, especially for those of us who had been involved in planning the curriculum if not from the outset, then for the previous year or so. The students' capacity for mature reflection on their learning experience exceeded all of our expectations. This year we will have two years' worth of student portfolios to mark and I am hopeful we can meet this target again. We have set ourselves a standard which we cannot renege on now. I feel nonetheless that the continued adoption of our vision for the new curriculum has required careful vigilance on my part and that without this oversight these critical curriculum "ingredients" have the potential to be diluted and in time slowly eroded. With so many new faces around the NCWG and continually changing unit coordinators for me to brief and so few of the original team left to carry the flame, I feel an overpowering burden of responsibility.

In the midst of all of these significant reforms the School has seen a steady departure of staff through resignations and transfers. The impact of these resignations is that the burden of responsibility for teaching and curriculum development falls on fewer shoulders. A small number of new appointments have been made as part of the School's succession planning, not as many extra staff as I had personally hoped the forecasted increase by 88% from 2003 to 2011 would have implied. These new appointments are keen to assert themselves but few of the new recruits, it seems to me, hold the new

curriculum plans as esteemed as I would have expected. Some of the new staff are already experimenting with new ideas which in my view deviate from the original template. I remind myself they cannot be expected to remain true to the letter of the original curriculum documents since none of them toiled over the plans for as long as I and the other members of the NCWG had done. As soon as one semester is rolled out more changes are recommended, sometimes "mid flight". I try to urge caution against too hasty modifications to the new curriculum, particularly in the absence of sufficient evidence and wonder if we have, through all of this, inadvertently created an insatiable appetite for change. The more I speak out at meetings, the more protective of the program I begin to sound and I retreat. Ownership must now be shared if this is to remain a curriculum with a future. Still it surprises me that an establishment based on the rigor of scientific endeavour should so quickly abandon an evidenced-based approach to curriculum evaluation. I am reminded of my conversation with Professor Samuel who experienced this same tension in the early 90s: "there's a lot of non evidence-based medical...stuff going on in the [medical education] community at the moment" ...anecdotal thoughts driving curriculum review". Here we are over 20 years later and the same criticism might be leveled.

Curriculum planning meetings have quickly been replaced by curriculum implementation meetings. Unfortunately the turnover of staff translates into lost opportunities to consolidate and yet somehow we lunge from one semester to the next with just enough resources each time to allow us to remain faithful to the original plans.

I find I am becoming less connected with the NCWG. I listen quietly and summarize intermittently, increasingly coaxing more than directing the discussions. As I look around the planning table I know that each and every member of the NCWG – including the newer membership – has worked tirelessly and has invested so much of themselves in this project and I am confident will continue to do so. But when will it all be over for them? Will it ever really be over? It seems one wave of change overtakes the next in relentless succession. This whole experience of curriculum reform has been, as Curry (2002) describes, "a marathon and not a sprint" (p. 1073).

The deceiving aspect for me has been the absence of a finishing line. What defines this "marathon" for me has been the sense of continual movement. I presumed this movement would take us in a forwards direction – away from the past and towards a better curriculum. Yet many of the aspects I described on my landscape looked similar to those described to me by voices spanning SoM's 42 year history. If the movement had been forward it seemed unlikely we should have encountered these features again.

I am reminded of a comment I had heard in one of the many workshops where the new curriculum was being discussed. One of the longstanding staff members who was about to retire and who had decided not to engage publicly in the new curriculum reform project (but whom I later found out had provided some very strategic educational support in private to his successor before he left) eagerly grasped the microphone at one of these meetings and with conviction expressed the following sentiments: "People think we have not changed – or don't want to embrace the new change... but we have changed... It's just that we have changed back again!" I have often reflected on that statement since then. In these words he captured the essential elements of the continual movement which I have experienced as ever present in my professional life as curriculum reformist. This colleague who would likely have been labeled by me at the start of this project as a "Laggard" using Rogers' taxonomy (1995) or scored "0" on the Stage of Concern or Level of Use indicators (Hall, 1979; Hall, 1985; Hall & Hord, 1987) was convinced that he had travelled further than his peers by embracing change. Recognizing the limitations of the new place he had found himself, he chose to return to the previous place he had occupied on his map. This place could be described disparagingly as retreating to the traditional, familiar "way of doing things", but in fact for him it was an evidence-based decision he had taken *not* to participate in the recent round of curriculum reforms. I have now come to understand and respect that decision without judgement.

Over the course of this project several key visionaries have separated from the process for various reasons, in some cases over conflicting ideologies such as what the project proposed to do or because of the way we were approaching the task. Now I am able to take fuller account of their perspectives through reflecting on my own experience. I am

also able now to acknowledge the equally remarkable colleagues who chose not to engage at all in the planning stages but are ready now to become involved in implementation. I have come to know and respect them all – those who joined the reform project early on and are still here, those who came and left in dispute, those who came and left because of competing pressures on their time and those who simply chose not to engage with the planning phase at all but are ready now to play their part in delivery. I have found there are many ways in which people can contribute to curriculum reform and not all of them easily categorized by a taxonomy.

Metaphorically speaking, this personal experience of change has been as if I entered a moving river which passes in its course trees, grasslands and distant mountains. Whilst in the current I try to force the river to change direction. The only way to divert the river's flow is to use large boulders and logs. An ambitious undertaking and only possible if I can convince a sufficient number of colleagues that diverting the river's course is truly warranted. They step into the river to help me move the boulders in place. In time, with sufficient obstacles in the river's old course we succeed. The final result remains a river passing in its course trees and grasslands and distant mountains.

Through all of this, I have began to recognize that I was secretly harbouring a desire to reach a place on this journey where all curriculum reform would cease, even if temporarily. I saw this as a quiet "neutral place" where we could embrace our new position with the pleasure that comes from well-earned success. I don't recall reaching that place anywhere on this journey, or if I did it passed me by, unnoticed.

As I reflect on this I begin to recognize another serious flaw in my own assumptions about the process of reform. I had come to regard everything significant that occurred in relation to curriculum reform at Southern State as having occurred since I took up my post in October 2002, and as a direct consequence of my interventions. If I stopped, then the process would cease and if my journey ended, then the reform project would end. Yet I knew from having watched other colleagues join and then leave the project that we were all dispensable. I also knew from discussions with colleagues and former Deans that they each had different distinct points of reference on this project and none of us

shared a uniform view about when and how it all started. Although ostensibly travelling the same road in the same time zone, not everyone saw the same landmark features I did. Mountains to me were flat terrain to others. Rivers to me were not featured on others' maps at all.

Over time the project has generated so much momentum that it has indeed taken on a life of its own and my part in it has been diminishing with each passing day. What started as a trickle, which I thought would never well up, became a flow and then a stream which I deceived myself I was controlling and has now become a torrent of change which, it seems, none of us alone can fully dominate.

An overseas opportunity in medical education has caught my attention. It feels the right thing to do and I apply.

Perhaps it is just as well for I feel it is time to hand over the baton. Maybe each one of us who had retired from the project, including now myself, had grown "weary of continuous change" (Caldwell, 2002 p. 844). I recollect Simon saying to me that he felt change "makes everybody weary at times, it tires people out". Perhaps I too have now fully played my part and it is time for me to step out of this moving river and as Curry (2002) points out "take care of myself". Curry advises those engaged in medical curriculum reform to "know the source of your energy, your spirit" and to "take pains to constantly renew the supply. Protect and nourish those resources" (p. 1073).

November 2008

It is now five years since the major curriculum reform project began in Southern State and three years exactly since the AMC handed down its decision to allow Southern State Medical School to proceed with its new medical curriculum. Although I left the School during the implementation of the second year of the new program to take up an appointment as Vice Dean for Medical Education in a large international medical school based in Europe (Northern Medical School), I have stayed in regular contact with the Dean who has kept me apprised of the developments since then.

In an email to me in January 2008, the Dean sent a copy of the report of the most recent accreditation visit which was held in October 2007, four months following my departure. He described the findings of the Report as being very positive for SoM, adding in flattery that "a great deal of credit for that outcome goes to you." As I read carefully through the document I found several specific references to the output of our three years' work between 2002 and 2005 such as the "clearly articulated medical graduate profile", and "the extensive involvement of a broad range of stakeholders in helping define the School's mission and objectives" (AMC, 2007, p.1) . References to the curriculum design and educational methods employed, such as the use of case-based learning, were also praised:

> The school is to be congratulated on developing a curriculum model that is consistent with the educational objectives of the course.... a strong foundation in basic science and communication with five intersecting themes (p.12).

I recalled the many hours we spent debating those five themes and their content and how to ensure an appropriate balance of all five themes across all years of the program. This Report was strong endorsement that those ideas had not only "looked good on paper" (as had been one of the comments made to me by one of the team just as we dispatched our final submission in November 2005), but had withstood the test of time and continued to be valued by the staff and students who followed. I skipped further through the Report to the section on Assessment (always the most challenging aspect of any medical curriculum) and also found a fulsome endorsement of our assessment strategy: "the team was impressed by the way the assessment is well documented and clearly linked with the integrated and thematic construction of the curriculum" (p.17).

The University media release that accompanied the AMC Report, read:

> Southern State School of Medicine receives full marks in accreditation.
> The School of Medicine's new medical course has been accredited until December 2012. This is the longest accreditation period the Australian Medical Council is able to award, and according to the Dean of the Faculty of Health

> Science, Professor Phillips, puts to rest any concerns raised in the 1990s about the viability of the school's future.

In August 2008, I had occasion to meet the Dean personally at an international medical education conference. He was still in high spirits over the review of the new medical curriculum at Southern State and reported that despite a reduced-in-size Medical Education Unit, the staff across the School remained committed to the key principles of the new curriculum including its delivery and assessment around the five themes. He also reported that tragically one of the five theme coordinators had passed away. As I had not heard this news until then, I was quite shocked. In fact the news of the curriculum SoM paled in significance and I felt profoundly and unexpectedly morose. It was as if I had lost a very dear friend, although all we ever discussed at our fortnightly meetings for the three years was the new curriculum. Paul had been the humorist in the group, witty and sharp and yet always poised to remind us of the need for students from the first year of study, to explore the ethical, legal, social and spiritual dimensions of medicine.

I spent a quiet night in my hotel room that evening, mourning the loss of a colleague and co-visionary and reminiscing about those three years we worked tirelessly together. I should have been celebrating that night the news of the enduring vision for the curriculum at SoM that seemed to have defied the odds. Yet all I could see that night in my mind's eye was Paul arriving late as he often did to the NCWG meetings in the Board Room. On his arrival he would immediately engage in repartee with one or other of the 15 members of the group. I as Chair saw this more as a distraction being more usually preoccupied with some detail of the agenda we needed to progress. With the passage of time I am left with the memories of the people who contributed to change at SoM; colleagues who toiled unstintingly for a better curriculum. Paul stayed loyal to the project from the day he joined as a Theme Coordinator. In fact he stayed on well after I had gone. I am also left with the distinct memory of other colleagues who likewise worked diligently on the reform project against much resistance from their peers and oftentimes questioning their own judgment but who for one reason or another became separated from the team. I can also hear the words and see clearly the faces of colleagues whose contribution was to stand back conspicuously from the curriculum planning project, awaiting the emergence of sound evidence to support the reforms we were

advocating. These faces have endured for me well beyond the project's planning, process and outcomes. I feel certain every one of us was affected by this experience of change, whether by textbook description they conformed to "laggard" or "early adopter" or whatever their "level of concern".

I commenced my new post in Northern Medical School in July 2007, and once again found myself taking up a new appointment in Medical Education without a predecessor to provide a "hand-over" and at a time when most of the other academics were taking their annual leave. The Dean of the Northern Medical School had a reform agenda but it was incremental not significant reform he had in mind. This pace would suit me well, I felt, given my recent experience.

As I sat in my new office in that first northern hemisphere summer I decided this time on a more moderately paced commencement than in the summer of 2002. I was handed a few documents by the Dean to "get me started" and reading through these came upon several curriculum reviews. My experience at SoM had also taught me to carefully read and enquire about all that had gone on before. I had come to know these as the three "Cs"; the context of reform in a medical school, the culture of the organization and the commitment to reform. Questions that immediately arose in my mind included: Why is this reform happening now? Who wants it to happen? Has it been attempted before?

One particular previous review which had been conducted three years previously in November 2005 caught my attention.

At that time Northern Medical School had decided to appoint an independent international review panel, chaired by an eminent Professor of Medical Education, to conduct a review of the medical degree programme using the global World Federation for Medical Education (World Federation for Medical Education, 2003)[34] standards. This review was to augment the existing accreditation framework operated by the local medical council. The process of engaging an international panel of medical educationalists using the WFME standards to provide feedback to a medical school was

[34] WFME www.wfme.org

hailed as leading edge and progressive, and proved to be a useful way for Northern Medical School (an international medical school) to ensure that all aspects of the school's aims, structures and processes were carefully explored. The November 2005 review had listed numerous specific areas for improvement. As far as I could ascertain no plans had been made for a formal follow-up visit and this seemed to me the obvious place to start my new journey of curriculum reform.

I found myself being drawn excitedly towards the now familiar task of preparing a medical school for an external review using the same WFME standards (WFME, 2003) as the AMC had been based on. I was very familiar with these standards and their underlying philosophy of institutional self review sat comfortably with me:

> *The primary intention of WFME in introducing an instrument for quality improvement is to provide a new framework against which medical schools can measure themselves in voluntary institutional self evaluation and self-improvement processes.*
>
> (WFME, 2003, p.7)

As the task was similar to my work in the southern hemisphere, I had the opportunity this time to reflect carefully on my approach. The context was different. This time I was working with a 300 year old institution, the curriculum was already being implemented and my task was to facilitate gradual reform of curriculum assessment, delivery and evaluation as well as to support staff development in medical education. A project management approach was acceptable to the staff and I once again sought out key champions with whom I could share the burden of responsibility for reform. The context at Northern Medical School I had decided was more about consolidating the new vision of curriculum (as distinct from developing a new vision) hence the title of my suggested 50 page project plan: "Road Map Towards Excellence: Consolidation the Vision". As I drafted this project plan I felt confident I had and could continue to make a significant contribution to reform in medical education and that the period 2002 to 2005 had taught me much about the process, but more importantly about my place in a change landscape.

As I became more immersed in the work, I felt myself increasingly referring to my experience in SoM and the lessons I had learnt. As I recruited staff I was acutely aware

of how I and others at SoM had been "altered by" curriculum reform. These reflections had been given a voice for the first time since 2002 when I sat the interview for this post. One of the most insightful questions I was asked by the interview panel in late February 2007 was, "What has your last experience of curriculum change taught you about yourself and your approach to change management?" It was a question I was not fully expecting but I responded frankly. I had learnt a great deal about the application of change management theory in the medical education setting and so began my response with the need for a clear vision and an appropriate communication strategy to deliver the message of reform and the need to set an appropriate pace for curriculum reform. I also stressed the need to establish in the minds of faculty the need for change and to incorporate change into everyday practice. I referred back to my experience at SoM and what this had taught me about the benefit of defining the journey for others. What had worked well for me before was the clear description of a mission or "capstone" statement of commitment for the new curriculum which articulated what the curriculum promised to "learners, to teachers and to other stakeholders" (Curry, 2002 p. 1068). Although at the time I felt frustrated, we had spent so much time defining our mission and our "medical graduate profile", and these became the most enduring elements of the curriculum. Neither did I regret the effort I took in articulating the NCWG progress in our regular newsletter. Although at times I was quite concerned the communication strategy was not reaching our intended target audience (Kreps, 1990; Dannefer, Johnston et al., 1998), the defining moment for me was at a workshop in the Botanical Gardens one full year into the project, when it was apparent to me a significant number of teaching staff had been quietly reading every line of the communications carefully. I knew from the informed and challenging questions they asked that they were familiar with the proposed organization and content of the new curriculum – even if the only actual feedback on the newsletter I received was to correct a grammatical error.

These principles were not new. They had stood me in good stead as I led curriculum reform in SoM. However, I knew they alone would not be sufficient.

I knew now that I could expect to be altered myself by the change process and that it would effect not only me but others around me. To these reflections then I added at my

selection interview that I felt I had come to know change was not merely a "process" I could administer, conduct or deal out "at arm's length," but rather the process of change would need to be very carefully understood in terms of its potential impact on myself and others. I now looked upon change with much greater respect than I had done before and had come to regard it as one would a drug with potentially harmful and unexpected side effects which would require careful monitoring. I explained to the panel that I would expect curriculum change to be experienced by faculty in different and sometimes unanticipated ways and that I could expect varying degrees of value to be placed by staff on new curriculum initiatives. Some would consider curriculum change a menace or even a hazard to be avoided, while others would embrace change wholeheartedly. But I went on to explain that I no longer saw the failure to adopt change at face value as a sign of resistance which would need to be overcome, but rather a call to listen and explore and if necessary reconsider my *own* position.

As I left the interview panel, I felt a little embarrassed as if too much had been spoken and too passionately. Nonetheless I had found the interview cathartic. I had been engaged in an honest and frank discussion about curriculum reform, based on real experience and had enjoyed the opportunity to do so with complete strangers. Two days later I was offered the new post. I accepted.

Now 18 months after joining the Northern Medical School we have recently completed the scheduled follow-up visit which entailed another week-long in-depth external review by a panel of internationally renowned medical educationalists. I once again led the project which oversaw a review of every aspect of the Medical School's operations including student selection; modes of curriculum delivery; curriculum assessment; governance; student and staff support and curriculum evaluation. Northern Medical School is still coming to terms with the preliminary review findings which thankfully demonstrated significant progress against each of the nine WFME standards in the course of the three years. I modeled the week long review on the Southern State experience which entailed 65 representations being made by faculty over a five-day period, supported by extensive documentation which was prepared in advance.

What I had learnt from previous experience at SoM about the technical aspects of the process of curriculum reform I applied to this 18 month long project and it was encouraging to find the international panel's preliminary findings recognized and endorsed the particular initiatives I had encouraged the School to undertake in the lead up to the visit. Although the definitive report is still pending, the preliminary report made special mention for instance of efforts such as the careful definition and mapping of curriculum outcomes, significantly enhanced curriculum evaluation activities. Included in the preliminary findings was high praise for the whole institution, which was described as demonstrating "profound engagement" in the educational mission and strong commitment to medical education and training.

What I previously learnt about myself and the lived experience of change I am still applying. Acutely aware of the potential impact of change on others as well as myself, I tread much more cautiously than before.

Concluding Comments

Through a retelling of the lived experience of curriculum reform I was able to focus the gaze on some of my own personally encountered emotions, reactions, concerns, sympathies and frustrations whilst planning a new medical curriculum. My own account of leading curriculum reform is interspersed with the voices of others also working on the same project and responsible for curriculum change. Together these perspectives illustrate varying degrees of conflict and divergence of opinion, as well as synergy. Our points of departure on this journey of reform were each quite different and, extending the journey metaphor, our individual destinations were also different.

My contribution as narrative researcher has been to pick up the threads of my own story and the contributions from colleagues and weave them into a tapestry that brings what has been described as an "order and meaningfulness" (Polkinghorne, 1995 p. 16) into the description and yet allow all the stories to remain continuous, distinct and intact. This is done not to bundle together "like with like" or match similar colours and patterns, but rather to allow the focus on contrast and tension where they exist, and so bring into view perspectives that might otherwise be lost.

I have come to earnestly reflect upon the meaning of my own and others' narratives, recognizing their inherent value in both understanding and shaping curriculum reform.

My Own Voice Revisited

This research has engaged me at a particular time in my own professional life when I have come to recognize the inherent value of my own story without concern that it may be, as Chase (2005) describes, "self-indulgent" (p. 666). On the contrary, I have made a conscious effort to "speak up" in this research text, recognizing that whilst this can often be difficult (Ely, 2007, p.574), what I have to say, other medical educators considering embarking on curriculum reform may well want to hear. My story permits a window into now six years of my own professional life immersed in curriculum reform. Incorporating my own voice was intentional and designed to take the reader somewhere he or she might otherwise not get to (Behar, 1996, p.14). At times, I have felt that I have shared more than I had intended in the telling of my story and yet I have surprised myself that the telling has not only proven easier than I expected, but also therapeutic. As I wrote I came to understand more fully what Mattingly (2007) points out when describing narrative, as providing coherence to the chaos created by illness (p. 407).

In a similar way, I have found that telling my story and listening to the interpreted experience of others has helped me make sense of what has otherwise been a chaotic period in my own professional landscape. I also concur with Richardson's earlier observation (1994) that writing about a topic can help us reach a deeper level of understanding: "a way of finding out about yourself... a method of discovery and analysis" (p. 516). Ely (2007) writes "There is no getting around it. We write to know. We write to learn. We write to discover" (p. 570). The process of committing my own words to paper allowed me to hold a mirror up to my own interpretations and interrogate them more carefully.

Others' Voices Briefly Revisited

Cohen (1991) says we rarely have the opportunity to hear "lengthy ruminations by real teachers", to which I would add it is even rarer to hear from real medical teachers.

Somehow, the hallowed halls of the medical school have held captive the many voices of medical teachers. Arguably part of the reason for this is the stranglehold that the positivist tradition has over the voices of these men and women. The long-held claim that reality can only be grounded in empirical observations of facts does not create sufficient space for the human voice in the context of medical education. Important stories of the lived experience of medical curriculum reform have remained silent. Clandinin and Rosiek (2007) describe the inevitable loss of "large regions of human experience that influence human affairs" (p. 44), which is left unattended to because of a lack of attention to these alternative epistemologies. A slowly increasing number of medical academics though are arguing for a greater emphasis on qualitative research, including narrative, particularly in the clinical domain where doctor and patient come together in and through narrative (Charon, 2006, 2001; Hurwitz, 2004; Bleakely, 2005).

This study provides some of the insights we currently lack in medical education. These are stories of successful medical educators and curriculum reformists, told in their own words, which attempt a description of that experience of change that "remains within the stream of human lives" (Clandinin & Rosiek, 2007, p.44). These are stories which take the immediate human experience (in this case the experience of change in a medical school) and focus on the temporal, spatial, and relational aspects, attempting to answer the question: what is it really like to reform a traditional medical school? What are the challenges facing medical teachers as they grapple with modern reforms in education and attempt to incorporate best practice in their medical school? These are stories from which "would be" curriculum reformists can draw inspiration. Apart from my own voice as Director of a foundation Medical Education Unit returning to my alma mater to lead curriculum change, included in these pages is the voice of a medical specialist returning from overseas with experience of education reform, not keen to be regarded as visionary or passionate about change. Acutely aware of the resource limitations that exist in his own medical school, he is eager to ensure the changes proposed are sustainable in the long term. There is also the voice of a recently promoted medical specialist who finds herself immersed in the reform process and grappling with her distance away from the decision making central executive of the School, but determined to interpret the curriculum reforms locally so that her students and colleagues are not disadvantaged,

and how the overwhelming desire to succeed (and justify her colleagues' confidence in her) in the face of adversity dominates her professional landscape. There is the voice of the psychologist invited for the first time in her career to make a contribution to the medical curriculum after two decades of teaching medical students. Finally there are the voices of Deans past and present who have each tackled curriculum reform in the same medical school over 42 years during each of their terms in office. These are stories of friendships gained and lost, internal conflict and role ambiguity, public sieges and private stand-offs, momentary celebrations, denouncement and deprecation, institutional loyalty and perseverance, marathons and sprints to a constantly moving finish line. These are real stories of curriculum change permeated by frustration, elation, betrayal, idealism, resignation, zeal, indifference, pragmatism, resistance, uncertainty and chronically unfinished business. Each account is distinct through contradiction, incongruity and ambiguity, and yet each account becomes the means for personal and professional educator transformation in the ever-changing landscape that is curriculum reform.

Six years later I find myself poised for action awaiting the results of yet another institutional review. This time I am on the other side of the globe. A different medical school with a different context and culture but, as before a medical school prepared to commit itself to curriculum reform and all that that entails. I recognise some of the features of this professional landscape and feel at times I have come full circle. Instinctively however I know this to be merely another point of departure on a continuing personal and professional journey

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Appendices

1

Dear Dr/Professor

We would like to invite your participation in the following research project entitled:

Curriculum Reform; A Narrative Journey

The following information about the project will be helpful to your understanding of what is involved.

The study can best be described as a 'narrative study' in that it seeks to gather and interpret the "stories" of those academics involved in the formative years of the Southern State School of Medicine (SoM), particularly those involved in the development of the initial medical curriculum.

The study has two components. The first is to collate the narrative experience of those involved in the original curriculum that commenced in the 1960s. The second component is to collate the reflections for those involved in the current process of major curriculum reform at the School.

As you were involved in curriculum development during your tenure as Dean your personal reflections on this process are sought.

At no time in the history of the School has there been an attempt to capture the personal reflections of those involved in curriculum reform. It is anticipated that the case studies from this research may assist those undertaking curriculum reform in the future.

You have been approached because of the key role you have played in the reform of the medical curriculum at the SoM. Other key foundation academics have also been invited to participate.

If you agree to participate you will be interviewed for no more than an hour and a half and this will be recorded. For the purpose of anonymity a pseudonym will be used to protect your real identity. The recorded transcripts will be sent to you for your amending or clarification. This will give you the opportunity to edit modify or withdraw any comments. Once the record is acceptable to you the tapes will be destroyed. The questions can take the form: "Please tell me about your involvement with the establishment of the original curriculum?" "What were the key challenges facing you at

that time?" "What attracted you to medical education and in particular a new medical course in Southern State"?
No personal details will be sought as part of this study and if any is inadvertently given it will be removed from the record. Only personal reflections on the curriculum development process will be entered in to the analysis.

The purpose of the study is to construct together your understanding of what it is like to be involved in curriculum reform at the SoM.

The location for the interviews can be mutually agreed and will endeavor to cause the least possible disruption to your usual routine.

All participants may elect to withdraw from the study at any time **without effect or explanation.**

The use of pseudonyms will go some ways towards protecting anonymity, however it must be understood that in a small school the identity of participants may be recognized despite best attempts.
The tapes and transcripts will be kept for 5 years under lock and key at the Medical Education Unit, SoM.

There is unfortunately no provision for reimbursement for participation in this study. Cab charges will however be provided to and from the interview setting wherever that location is agreed.

This study has been approved by the Southern State Social Sciences Human Research Ethics Committee. If you have any concerns of an ethical nature or complaints about the manner in which the project is conducted, you may contact the Executive Officer of the Southern State the Social Sciences Human Research Ethics Committee and she can direct you to the Chair of the relevant Ethics Committee reviewing this research:
Executive Officer: Amanda McAully (6226 2763)

All participants will review all the transcripts as the interviews unfold. You will be kept informed of any significant findings as they might affect you. The use of pseudonyms allocated to you will go some ways towards protecting your identity throughout this process and if any data from this research is published.
The list of participants will be kept separate from the data files (which will be kept under lock and key in a filing cabinet at the SoM) to preserve anonymity.

Completion of the attached consent form is required in order to accept your participation in this study.

If you have any further questions relating to the study Dr Mac Carrick can be contacted on the following numbers:

62264771.

We sincerely look forward to your participation in this research.

Thank you for your time.

2

Dear Dr/Professor

We would like to invite your participation in the following research project entitled:

Curriculum Reform; A Narrative Journey

The following information about the project will be helpful to your understanding of what is involved.

The study can best be described as a 'narrative study' in that it seeks to gather and interpret the "stories" of those academics involved in the formative years of the Southern State School of Medicine (SoM), particularly those involved in the development of the initial medical curriculum.

The study has two components. The first is to collate the narrative experience of those involved in the original curriculum that commenced in the 1960s. The second component is to collate the reflections for those involved in the current process of major curriculum reform at the School.

As you were involved in curriculum development during your tenure as Dean your personal reflections on this process are sought.

At no time in the history of the School has there been an attempt to capture the personal reflections of those involved in curriculum reform. It is anticipated that the case studies from this research may assist those undertaking curriculum reform in the future.

You have been approached because of the key role you have played in the reform of the medical curriculum at the SoM. Other key foundation academics have also been invited to participate.

If you agree to participate you will be interviewed for no more than an hour and a half and this will be recorded. For the purpose of anonymity a pseudonym will be used to protect your real identity. The recorded transcripts will be sent to you for your amending or clarification. This will give you the opportunity to edit modify or withdraw any comments. Once the record is acceptable to you the tapes will be destroyed. The questions can take the form: "Please tell me about your involvement with the establishment of the original curriculum?" "What were the key challenges facing you at that time?" "What attracted you to medical education and in particular a new medical course in Southern State"?

No personal details will be sought as part of this study and if any is inadvertently given it will be removed from the record. Only personal reflections on the curriculum development process will be entered in to the analysis.

The purpose of the study is to construct together your understanding of what it is like to be involved in curriculum reform at the SoM.

The location for the interviews can be mutually agreed and will endeavor to cause the least possible disruption to your usual routine.

All participants may elect to withdraw from the study at any time **without effect or explanation.**

The use of pseudonyms will go some ways towards protecting anonymity, however it must be understood that in a small school the identity of participants may be recognized despite best attempts.
The tapes and transcripts will be kept for 5 years under lock and key at the Medical Education Unit, SoM.

There is unfortunately no provision for reimbursement for participation in this study. Cab charges will however be provided to and from the interview setting wherever that location is agreed.

This study has been approved by the Southern State Social Sciences Human Research Ethics Committee. If you have any concerns of an ethical nature or complaints about the manner in which the project is conducted, you may contact the Executive Officer of the Southern State the Social Sciences Human Research Ethics Committee and she can direct you to the Chair of the relevant Ethics Committee reviewing this research:
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The list of participants will be kept separate from the data files (which will be kept under lock and key in a filing cabinet at the SoM) to preserve anonymity.

Completion of the attached consent form is required in order to accept your participation in this study.

If you have any further questions relating to the study Dr Mac Carrick can be contacted on the following numbers:
62264771.

We sincerely look forward to your participation in this research.

Thank you for your time.

3

CONSENT FORM

Title of Project: *Curriculum Reform; A Narrative Journey*

- I have read and understood the 'Information Sheet' for this study.
- The nature and possible effects of the study have been explained to me.
- I understand that the study involves the recording of interviews with me about my involvement in curriculum development at the SoM.
- I understand that my identity will be kept confidential and that any information I supply to the researcher will be used only for the purposes of the research.
- I understand that loss of anonymity is the most relevant risk but that the procedures described will endeavour to protect me against this risk.
- I understand that despite these endeavours I may still be identifiable due to the position I hold or the nature of my work / occupation (eg. lavender farmer, Northwest vineyard operator).
- I understand that I may view the transcripts after each interview and at any time thereafter.
- I understand that all research data will be securely stored on the SoM premises for a period of 5 years. The data will be destroyed at the end of 5 years.
- Any questions that I have asked have been answered to my satisfaction.
- I agree that research data gathered for the study may be published
- I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish, may request that any personal data gathered be withdrawn from the research.

Name of participant _____

Signature of participant _____ Date _____

I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

Name of investigator _____

Signature of investigator _____ Date _____

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Interview Schedule and Guiding Questions

Participants of the recent curriculum reform process will be interviewed on two occasions. The first interview will be scheduled prior to the Australian Medical Council's (AMC) decision on the state of readiness of the Medical School to implement the new 5-year medical curriculum. This determination is due to be made following a week- long visit to the School in May 2005. The final interview will be scheduled for the weeks following the visit when the participants have had adequate time to reflect upon the AMC's findings. Foundation academics will be interviewed once (if this is felt to be sufficient time to explore their past involvement in curriculum reform) about their involvement in the development of the medical School's original 6- year curriculum.

The schedule for the current curriculum reform team will be as follows:

1st Interview:

Open ended questions will be used. The questions will seek to establish the participants' role in medical curriculum development past and present. The initial interview will provide time to allow participants to come to terms with the purpose and meaning of the interviews which is to help them construct meaning of the curriculum reform events they are (were) involved in. The first interview will focus on their role as medical educators and specifically curriculum reformists.

Example questions:

- "Can you *tell me about how you came to be involved in curriculum development?"*
- *"Were you always interested in this sort of work?"*
- *"Were there any particular events in your life which helped develop or affirm this interest?"*

2nd Interview:

Open ended questions will again be used. The questions will seek to "drill" down and facilitate the detailed "telling" of the participants' stories. Photographs, media stories, documents pertaining to the development of the curricula and AMC reports will be used to facilitate recall and generate discussion. The second interview aims to capture lived experience over time

Example questions:

- *"How did you feel when we presented this to the Faculty?"*
- *"What was this part of the project like for you?"*
- *"What were the challenges you faced here?"*
- *"What particular obstacles did you feel you needed to overcome?"*
- *"What was your reaction to this newspaper article?"*
- *''How did you feel when this AMC submission was received?"*
- *"What were your thoughts about the curriculum reform process in the lead up to the submission?"*
- *In the last interview you described...What was that experience like for you? Have things changed for you since then?"*

The same guiding questions were used when interviewing former Deans.